DOCUMENT RESUME

ED 179 881 CG 014 026

AUTHOR	Moore, Charlotte Dickinson
TITLE	Understanding Neurotic Disorder.
INSTITUTION	National Inst. of Mental Health (DHEW), Rockville, Md. Div. of Scientific and Public Information.
SPONS AGENCY	Department of Health, Education, and Welfare, Washington, D.C.
REPORT NO	DHEW-ADM-78-614
PUB DATE	78
NOTE	50p.
AVAILABLE FROM	Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (Stock No. 017-024-00774-9)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	Adjustment Problems: Adults: Behavior Patterns: *Maladjustment: *Mental Health: *Mental Illness: *Neurosis: Prevention: *Psychological Characteristics: *Psychological Patterns

ABSTRACT

Understanding, one of the chief components of prevention in mental health, is not for the researcher or clinician only, but for all who may be concerned with their own conflict and pain or that of family members. Looking at neurotic disorders requires the examination of guilt which burdens individuals as they realize their failure to fulfill responsibilities to themselves and others, and also the resulting anxiety caused by hurtful experiences which may impede mature responses in the future. The condition of neurosis, which is virtually impossible to quantify statistically, does present one significant finding from numerous research studies, i.e., neurotic individuals frequently come from homes with a high proportion of persons having neurotic symptoms. Several therapeutic views provide strategies for dealing with neurosis, particularly psychoanalytic theory, behavior therapy, and humanist-existential therapies. Different types of neurotic disorder can be classified: anxiety, depersonalization, depression, hypochondria, hysteria, neurasthenia, obsessive-compulsive behaviors, and phobias. (Author/HLM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED179881

Understanding Neurotic Disorder

by

Charlotte Dickinson Moore

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

CG 014 026

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

National Institute of Mental Health
Division of Scientific and Public Information
Mental Health Studies and Reports Branch
5600 Fishers Lane
Rockville, Maryland 20857

DHEW Publication No. (ADM) 78-614
Printed 1978

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Stock Number 017-024-00774-9

FOREWORD

A primary goal of the modern mental health practitioner, and of the National Institute of Mental Health (NIMH), is *prevention*—prevention of mental and emotional disorders or, at least, of their persistence, recurrence, and debilitating effects; prevention of unproductive and unhappy years; and prevention of public misunderstanding about emotional problems through education. Among these problems, neurotic disorder looms large. It is considered one of the most prevalent of the emotional disorders, difficult to define and to classify. The difficulty is understandable. Many symptoms may be described in terms comparable to those of the more serious psychotic and personality disorders; conversely, many symptoms resemble the habits, attitudes, and moods of the average man or woman. In addition, the syndrome has received less attention from researchers in recent years than the more flamboyant psychotic and drug-induced conditions, and many individuals who might be diagnosed as neurotic do not seek therapy, thus diminishing opportunities in that sector for the development of broader clinical and diagnostic experience.

The NIMH has moved toward the goal of prevention through support of research on treatment of emotional disorders and on the effects of anxiety and hostility on behavior. Because of the enormous public health and social consequences of this problem and greater awareness in this decade of the alarming spread of depression and anxiety, the NIMH believes that clearer classification of the disorder should be made and that, through systematic research, a number of questions should be addressed: Why are some cases of this disorder chronic while others remit spontaneously? Is there a genetic contribution? How do certain neuroses differ at different stages of life? What is the contribution of interfamily relationships and social class?

Understanding, one of the chief components of prevention in mental health, is not for the researcher or clinician only but for all who may be concerned with their own conflict and pain or that of family members. Understanding can be promoted by the provision of greater knowledge about the genesis and dynamics of psychic distress; by the evidence that many patterns of thought and behavior can flourish within what is called the normal range; and, most importantly, by the assurance that those patterns which prove maladaptive and distressing are treatable. The National Institute of Mental Health believes that this publication will aid in developing such understanding.

Francis N. Waldrop, M.D.
Acting Director
National Institute of Mental Health

Understanding Neurotic Disorder

"Whoever succeeded in draining the whole cup with grace?"

from a lecture, "The Stages of Life"
Carl Gustav Jung

The range of human emotions is as wide and varied as the spectrum on a decorator's color wheel. Such expressions as "purple with rage," "red with anger," or "white with fear" are as familiar as the names of the primary colors and, because they reflect experiences common to everyone, as old as man's first attempts to provide a verbal image of the human condition.

By varying the amount of light or darkness, white or black, added to a basic pigment, the artist can alter the value of a color. By varying the brightness or density, he can alter the intensity, turning red into maroon, yellow into dull gold, sky-blue into cloudy gray. So it is that most people find the days of their lives varying in value and intensity, some bright, some dreary and dull. When the density of anxiety, fear, and depression *dominate* a life, with no light to vary their dull hue, the result may be emotional disturbance.

Is there anyone who has not felt anxiety about some future event—a new job with increased responsibilities, a dinner party where everything must go right, or a move to a new neighborhood? Isn't there dread of the unknown mixed with a child's anticipation of the first day of school, and doesn't near-panic seize some grandparents at the approach of yet another birthday?

Who has never been depressed, blue on days when everything goes wrong, with a feeling of being useless and unloved? And who has not known depression and grief following the loss of someone dear?

To the *anxieties* familiar to all of us and to the moods of *depression*, whether caused by grief or just the ups and downs of living, fear may be added as a recognizable reaction. Eight-month-old babies fear strangers, and little children may be afraid of dogs for a time. Old, half-remembered tales and the daily news may fill us with alarm.

But just as most babies learn to respond to friendly smiles with shy smiles of their own and most children, after a few timorous advances, lose the sense of panic they felt at the approach of a

small, tail-wagging dog, so most people, as they mature, learn to handle anxious moments and blue periods as a part of living.

However, there are many whose lives are less than full and contented. Instead of coping with problems in everyday living, they have learned to avoid them. Since it has usually appeared easier to face even ordinary challenges with a rigid pattern of thought and action, such people eventually become unable to see for themselves the reasons for their self-defeating lifestyles, or seeing, they may be unable to change by themselves. As their concerns more habitually turn inward, their interpersonal relationships become more unsatisfactory. As they realize their failure to fulfill their responsibilities not only to others but to themselves, they become burdened with *guilt*. For many, the *anxiety* caused by a hurtful experience may impede mature responses in the future.

Physical symptoms accompanying this disorder vary, of course, from person to person, depending on the extent and nature of the problem. Generally, however, many of these symptoms are associated with the autonomic nervous system: palpitations, rapid or shallow breathing, dizziness, tremor, or tachycardia. There may also be such indications of anxiety as insomnia, restlessness, or unwarranted fatigue.

How Extensive Is Neurosis?

This condition, called *neurosis*, is virtually impossible to quantify statistically. The Division of Biometry and Epidemiology of the National Institute of Mental Health gives the following figures for 1975: 1.5 percent of admissions to State and county mental hospital inpatient units; 5.6 percent of admissions to private mental hospital inpatient units; and 8.2 percent of admissions to outpatient psychiatric services. The rates for each of these categories, per 100,000 population, are 2.8, 3.4, and 54.8, respectively. These figures exclude admissions to federally funded community mental health centers, the Veterans Administration (VA) psychiatric services, and private mental health practitioners; and they do not include persons who might be diagnosed as depressive neurotics.

The many forms in which the disorder can appear and the difficulty in discriminating between unusual behavior and mild disorders, or between neurotic and other disorders, make a statistical definition imprecise. Samplings of neurotic behavior patterns by epidemiologists, who discovered gradations from "mild" through "moderate" to "severe" and "incapacitating," demonstrate further the difficulty of cut-and-dried labeling.

These neurotic disorders should not be confused with personality disorders and certain other nonpsychotic mental disorders—paranoid personality, antisocial personality, passive-aggressive personality, for instance, nor with the psychotic disorders, such as schizophrenia or manic-depressive psychosis. And while neuroses

may be involved in problems such as marital dysfunction, such an assumption is not necessarily so. Here, again, the difficulty of diagnosis and hard statistics becomes apparent.

There is one significant fact which has emerged in all studies of the neurotic disorders: Neurotic individuals frequently come from homes with a high proportion of persons having neurotic symptoms, higher than the proportion of neurotics to the general population. On the other hand, statistical inference that more women than men suffer from neurosis does not seem particularly significant, since figures are based on the numbers who seek treatment, thus admitting to fears and anxiety which in our culture have been considered unmanly. It is beyond the power of a statistician to measure such factors as the cost of a neurotic handicap to society in loss of manpower or to family interactions in loss of harmony.

Despite the problems of statistical inaccuracy, there is fairly general acceptance among psychiatrists, psychologists, and other therapists of the classification as set by the American Psychiatric Association. Both their *Diagnostic and Statistical Manual of Mental Disorders*, 2nd Edition, (DSM II), published in 1968, and the 4th Edition of their *Psychiatric Glossary*, 1975, categorize the neuroses in eight broad divisions: *anxiety, depersonalization, depressive, hypochondriacal, hysterical, neurasthenic, obsessive compulsive,* and *phobic*. (DSM III will doubtless contain some changes in terminology, reflecting possible changes in the times and in the way therapists view the various disorders.)

Neurotic or Normal?

Neurosis, then, takes many forms, and much of its vocabulary contains words used pejoratively. The college roommate who keeps her sweaters in neat piles, her dresser drawers closed, and her books in a neat row on the desk instead of in tumbling stacks on the floor is not necessarily *obsessive compulsive*. Nor is the housewife who runs back from the car to make sure she turned off the iron a victim of *anxiety neurosis*, on the basis of that act alone. And moments of dread before one's first airplane flight do not, by themselves, constitute a *phobia*.

Since everyone suffers to some extent from inadequacies either real or imagined—poor self-image or identity problems, to borrow from current phraseology—or from the strain of coping with everyday problems and from anxiety, unhappiness, and loss, neurosis might be equated with a lower tolerance level for those problems. The word *normal* is not interpreted in the same way in every social group or culture, but self-control and responsibility, both personal and social, might form a general equation for it. The so-called normal person is not always problem- or guilt-free, always happy, or always successful. Instead, he is willing to accept responsibility for his failures rather than rationalizing or drawing into

his shell and usually tries to learn from mistakes and disappointment. His realistic perspective and positive self-concept evoke satisfactory interactions with others.

From this loose definition, the normal personality emerges as a broad framework within which many types of individual behavior patterns can flourish, each in its own social and cultural setting. Why then, with such a broad range of possibilities, do some individuals suffer from a false evaluation of reality, feel inferior to others who face the same stresses with little apparent difficulty, and succumb to self-defeat, despite the trouble, even anguish, these attitudes inflict on themselves and those around them?

Some Historical Views

Since earliest times, people have interpreted things they could not understand as a punishment by the spirits or a warning from the gods, whether those things be natural phenomena, such as eclipses or earthquakes, or unnatural behavior such as obsessively repetitious habits or deep, prolonged depression. In the story of Saul, the Old Testament describes the mental tortures of a man possessed by the forces of evil when, because of his disobedience, he was forsaken by God. From mythology come tales of men pursued by the Furies. And from the Greek tragedy *Oedipus* comes the name of a complex described in modern times as the feeling of a child for the parent of the opposite sex—abnormal if it hinders the normal development of other relationships in later years.

The word *neurosis* itself comes, via the Latin "nervus," meaning sinew or nerve, from the Greek word "nervon." From the ancient Greek word "phobus"—fear or flight—comes our word phobia, and from "therapeia," or treatment, the much-used *therapy* descends. *Hysteria* is derived from the Greek word "hystera," or womb, and reflects the notion that hysteria was a disorder confined to women, occurring because the uterus wandered to various parts of the body. (The Greek physician Hippocrates recommended marriage as the best remedy for this disorder—not as apt and scientific prescription as is usually attributed to the "father of modern medicine.")

Reflecting the artistic and intellectual spirit of his age, Hippocrates (460–357 B.C.) worked with his colleagues in a school of medicine which actively supplanted the mythology fostered by the hereditary priesthood in the temples with reliance on scientific observations and the use of clinical descriptions of physical and emotional disorders. He encompassed in his studies such modern topics as heredity, environment, brain pathology, brain disorders caused by injury, the importance of dreams—questions for which we are still seeking ultimate answers.

With a few exceptions, later steps toward understanding the complexities of man's mind and body were slow and faltering. After

Hippocrates came Asclepaides who, in the first century B.C., distinguished between acute and chronic mental illness; Aretaeus, near the end of that century, who not only described the phases of mania and melancholia, but deemed them part of the same illness; and Galen (130–200 A.D.) who maintained a scientific approach to mental illness and divided its causes into physical and mental.

Galen's influence was predominant for centuries. For more than a thousand years, few additional discoveries were added to the body of knowledge about the causes or the treatment of mental or emotional disorders. The early enlightenment was dimmed as society, even most theologians and physicians, returned to witchcraft, demonology, and superstition. During the Middle Ages, mass hysteria was not uncommon. In Western societies, where visual and auditory hallucinations were not considered special gifts, as they were in some other cultures, exorcism was employed as one of the gentler remedies for disturbed individuals. For psychotics—those unable to meet the ordinary requirements of living because of inappropriate behavior, a distorted view of reality, or perhaps an inability to think or remember—floggings, starving, and confinement in chains were but a few of the devices used to make the body too uncomfortable a place for the imps of Satan to remain. The severely neurotic and the personality disordered were considered to be witches, under the spell of evil, and were often accused of casting spells. And witchburning is a familiar story.

The 18th and 19th centuries saw giant steps in discoveries concerned with physical medicine—anatomy, neurology, and physiology. It was inevitable that attention to the causes of emotional and mental problems should follow. Brain pathology was blamed, with virtually no consideration of possible psychic origins. Among the eminent men who concerned themselves with the study of brain pathology was Emil Kraepelin (1856–1926), whose classification system categorized mental disorders by type. Kraepelin's system included predictions as to the course of each disorder, making even more significant his contribution to the study of psychologic and behavioral dysfunctioning, or psychopathology.

No longer would demons receive the blame for mental disorders. Slowly but surely, humane treatment began to take the place of chains and floggings. Mental and physical impairments and disorders could now be considered of equal importance, thus initiating studies which led to our century's dramatic findings in genetics, neurophysiology, drug therapies, and the biochemical malfunctioning which is believed to cause much emotional imbalance.

Some Therapeutic Views

Throughout time, the signs of neurosis were easily perceived—tremor, dizziness, palpitations of the heart, shallow or rapid breathing, extreme anxiety. Hysteria and obsessional manifesta-

270-937 O - 78 - 2

tions were relatively familiar. There was mention, too, of these symptoms in reports from military medicine. Until the latter half of the 19th century, however, there was no body of professional opinion about the causes of these conditions or even about names for them—"Nervous exhaustion" or "soldier's heart" certainly sounded more professional than the lay person's "eccentric" or "queer," but they were almost as inadequate. *Neurasthenia* appeared as a descriptive term in 1869 when the American physician Beard used it in presenting some of his cases, including a few whose present-day diagnosis would be *anxiety neurosis*. That term was first used by Freud in 1895 to describe symptoms which his contemporaries were calling neurasthenia.

Psychoanalytic Theory

Sigmund Freud (1856–1939) left his native Vienna in 1885 to round out his medical studies in Paris. As a neurologist, he had become interested in Dr. Jean Charcot's experiments on the powers of hypnosis as a cure for hysterical paralyses and anesthesias, meaning loss of sensation in a part of the body without loss of consciousness. (Hypnosis fascinated people of the early 19th century, and its chief practitioner, Anton Mesmer, who treated all sorts of symptoms with a kind of hypnotism which he called "animal magnetism," enriched our modern vocabulary—mesmerize, to hypnotize or spellbind, was derived from his name.) Observing the treatment of hysterical patients with hypnosis led to Freud's conviction that the unconscious hid many strong and unsuspected mental processes, a conviction which must have been the genesis of his tip-of-the-iceberg theory. He came to believe that the conscious mind, the tip that is revealed, is much smaller than the unconscious, the large unrevealed part whose force is unrealized.

Upon his return to Vienna, Freud worked for a time with a colleague who led his patients, mostly women, to talk freely about their problems while under hypnosis, a process which was revealing and seemed to bring them relief. Freud soon decided that hypnosis was unnecessary. His patients were induced to talk freely, with no pattern or logic and with little interruption, about any subject, a technique which came to be called *free association*. Through such rambling accounts, in which the individual was prone to dwell on unhappy or disturbing episodes, many of which had been lost for years in the memory or buried in the unconscious, Freud believed it possible to analyze or interpret the causes of the individual's neurotic disturbance. He studied dreams and interpreted them, since he believed that many elements of dreams are symbolic of concealed wishes and painful constraints.

Thus was born the therapeutic school known as *psychoanalysis*. (The prefix "psycho" is another contribution from the ancient Greeks, whose word for soul or "principle of life" was "psyche.")

The principal elements of psychoanalysis as conceived and practiced by Freud were *free association*; *dream interpretation*; *analysis* of the resistance which the patients showed toward certain unpleasant associations or to the latent, hidden meaning of their dreams; and *transference*, in which the analyst may come, during the treatment process, to represent to the patient the person in his past toward whom he held buried hostilities or by whom he had felt rejected.

Freud's psychoanalytic theory evolved from his view that human behavior is determined by the way the "id," the "ego" (both Latin pronouns), and the "superego" act upon each other. Id represents the instinct, unconscious and uncontrolled. It wants what it wants now, like the crying baby who wants his milk and will keep crying until he gets it. Nor does the id distinguish between the real and the false. This inability to defer satisfaction is known as the "pleasure principle," in contrast to the "reality principle" which indicates the control exercised by maturity and logic.

This control grows gradually with the development of the ego, the known, conscious part of the personality. Development of the ego is not as perceptible as the growth of a baby but, normally, the ego grows as the child grows. Its function is to perceive and react in a realistic fashion, at an appropriate rate according to age, satisfying wants and needs maturely in relation to the individual's physical maturation. Recognition by therapists that some of their patients need "ego strengthening" is well justified. The ego has a big job to do. Ideally, it is supposed to maintain the principles of pleasure and reality in equilibrium with such abstract concepts as right and wrong and with the demands of society.

This last important element, the conscience and the "ego-ideal," Freud named the *superego*, which begins to develop by about the age of 5, when the child has begun to absorb the "do's" and "don't's" of behavior and manners. He has learned which deeds will bring him approval, and which misdeeds, disapproval or punishment. More importantly, from the example of the significant people in his life, he is developing a conscience and discovering how to give pleasure to others. The *superego* is formed as these factors—conscience and ideals learned from parents and other teachers—become so fixed in the unconscious that self-control can take over from the outer controls which formerly governed his behavior.

In the psychoanalytic scheme, *neurosis* may occur when this sequence of development does not proceed more or less according to schedule. The individual is in trouble if the ego is unable to mitigate the demands of the id, of either its sexual instincts—*libido*, in Freudian terminology—or of its aggressive instincts. There is trouble, too, if the ego is powerless to help the id conform to the strictures of the superego and of the outside world. Conversely, the superego may take over to such an extent that all instinctive pleas-

ure and gratification cause anxiety and psychic pain. Unfortunate is the person for whom the superego takes all the fun out of life.

In either case, according to Freud's earlier postulation, the resulting anxiety, whether conscious or unconscious, is likely to lead to the development of a neurotic symptom. (Later, he was to see anxiety as the cause of the symptom.) The symptom alone may be enough to relieve the anxiety, with no apparent harm done to the individual's ability to function in most situations. However, if the anxiety continues to plague the person from time to time, the symptom may grow worse, erupting in physical distress. In fact, the *psychosomatic* ("soul" and "body") disorders such as migraine headaches, peptic ulcers, dermatitis, and hypertension are believed to have a partial basis in emotional stress and anxiety.

Often a *defense mechanism*, operating unconsciously, diverts these instinctual drives, which are consciously unacceptable, into more acceptable channels. One such process, called *sublimation*, occasionally produces highly creative individuals who are very worthwhile to society.

If the symptom worsens, on the other hand, it may cause the ego to generate behavior that is even more neurotic. The kind of symptom which develops, Freud believed, depends upon the period of psychic growth in which the anxiety-producing episode first took place. An interruption in normal development or problems in any one period will probably result in regression to the behavior of an earlier, more competent period of growth whenever undue stress occurs later in life. An individual who reacts to stressful exigencies in this way is said to be "fixated" at a certain phase—"oral," "anal," "phallic-Oedipal," and so on—terms which are rarely used by therapists today.

Much of the terminology which Freud used in describing his concepts concerning this psychodynamic approach to human development has found its way into our literature and everyday conversations. The terms have been used and misused, the ideas interpreted and misinterpreted. In justice, it is well to realize that some of Freud's descriptions of interpersonal relationships and of the milestones toward maturity were more figurative than literal. Certainly it is fair to attribute to Freud much of the present-day openness surrounding human sexuality, while remembering that many psychoanalysts and others interpret his term "sexual instincts" as "life instincts"—drive, gratification, creativity. Freud himself, the product of a prudish era, disapproved of the psychoanalytic solution of all emotional dilemmas through the unbridled gratification of sexual needs and in his later years considered the *aggressive* instinct as one of the major instincts of the id, along with the sexual, a concept which has not yet been thoroughly integrated into the psychoanalytic scheme.

Most people have a preconceived idea of the classic techniques of psychoanalytic therapy. Many of the notions are exaggerated or fallacious, however, because of movie and television scenes where the typical analyst, in thick, Viennese accents, interprets the dreams of his patient, who is lying on the typical couch. In reality, the treatment includes making the patient comfortable, in an easy chair or on a sofa, with no distractions. Frequently the therapist is seated behind the patient so that no visual clues will be revealed, an arrangement Freud favored, admitting that he did not want to look at patients all day.

Freud worked throughout his long life developing his system of beliefs and practice. His model of treatment has been the keystone of nearly all systems which have evolved in our century to help the mentally and emotionally disturbed, with modifications, alterations, and changes in interpretation and application to accommodate the convictions of other therapists and to fit the mood and tempo of the times. In recent decades, for instance, feelings of helplessness and alienation have largely replaced those of guilt as the underlying cause of the anxiety to which much neurotic despair is attributed, a change which mirrors the social and religious orientations of both eras.

Modifications in the Freudian mode began with two formerly ardent disciples of his, Alfred Adler (1870–1937) and Carl Gustav Jung (1875–1961). Although their apostasy brought anguish to all three men, it brought about a broadening of the psychotherapeutic concept (plus some currently fashionable additions to the professional and secular vocabulary, the "complexes" as Jung called them being one). Adler's approach, which he called Individual Psychology, replaced Freud's idea of *sexual urges* as the motivating force in life with *social urges*, and it placed the primary emphasis on man's will and effort. According to this theory, behavior is goal directed. It follows first, then, that neurosis should be seen as a way of salvaging self-esteem and, second, that the purpose of neurosis is the evasion of responsibilities which are an integral part of life and its work. Adler viewed neurotics as persons who had mistaken lifestyles and who could not exert the cooperation and social interest necessary for solving life's problems. He believed that the therapist's job, to be approached with humor, tact, and friendliness, was to arouse this social interest and cooperation and to encourage the patient. Since he saw negativism as a very human trait, a trait accentuated in the neurotic, Adler occasionally used it as a tool in treatment. By seeming to make negativism acceptable, he weakened its potency. And in encouraging his patients sometimes to laugh at their symptoms, but to consider them as a crutch to rely on when in great distress, Adler apparently discovered new ways of neutralizing the power of those symptoms.

Among Jung's contributions was the word association test, which he used to delineate individual complexes. At present, possi-

bly owing to the current interest in meditation and mysticism, there is a renewal of interest in the thought of the man who proposed the theory of the "collective unconscious." He believed that, in addition to the individual memories, dreams, and impulses buried within each person, there is a collection of memories that stem from man's beginnings, which Jung called "primordial images" or "archetypes." More familiar within the context of psychotherapy was his suggestion that one's personality is either extroverted, that is, more likely to find value and reality in the surrounding world, or introverted, inclined to find more value in the inward than in the outward experience. This view of what Jung called attitudes has been misunderstood and misinterpreted, so that usually we equate introversion with shyness, selfishness, and a wish for solitude. In turn, we interpret extroversion as an outgoing, breezy approach to life and to others and as unselfish and altruistic.

In the *analytic psychology* of Jung, mild neurosis is seen in lapses such as clumsiness and speech blunders, which some call "Freudian slips." All neuroses are deemed an inability to cope or to maintain control over the behavior. During his later years of practice, Dr. Jung's experience with older patients, especially with those who, in the world's view, had been successful but were, nevertheless, left with feelings of emptiness and waste, confirmed his belief that one's most important, most difficult goal was development of the self. His conviction, which seems to coincide with much of our contemporary thought, was that this development could take place by integrating into the consciousness one's inner self-experience, with all its dreams and fantasies, and by growing in one's own way.

Just as art and literature generally reflect the mood of their time, so did the work of the neo-Freudians, among them the psychoanalysts Harry Stack Sullivan and Karen Horney who, while following many of Freud's precepts, reflect the social upheaval of the post-World War I and Depression eras by their emphasis on sociocultural forces rather than on the libido and the id as the prime cause of emotional distress. They attacked the anxiety which they believed arose from a lack of love, feelings of inadequacy in interpersonal relationships, or unsatisfactory parent-child interactions, all of which they felt formed a neurotic approach to life.

Many people are being helped by therapists using psychoanalysis, although today, for many, our fast-paced life and economic considerations preclude the luxury of spending years under analysis. Short-term therapy based on the psychoanalytic model is available. The one-to-one patient-therapist situation is sometimes altered to make group therapy possible. In all of these the basic premise remains the same, however. Therapies descended from Freud's model are similar in the shared hope that patients

will gain insight into the reasons for their psychic maladjustment and will be able to work through their problems from that point.

Behavior Therapy

In contrast, there are at present many therapists who feel that the neurotic response is learned and can be unlearned and that working through the causes of neurotic habits may not be necessary for the achievement of normal behavior. Called Behavior Therapists, they differ also in their demand for experimental evidence and for quick treatment of specific symptoms, whether these be merely bad habits, true neurotic disabilities, or certain psychotic malfunctions. There has been criticism that a neurotic symptom relieved by this therapeutic method may be replaced by another if the cause of the neurotic response is not discovered and solved. Although there seems to be little foundation for this opinion, many therapists now use what has been termed behavioral analysis and include in their treatment repertoire information about the patient's environmental, social, and physical history as well as a determination of what factors trigger and what events reinforce the undesirable symptoms.

As the history of psychotherapeutic methods goes, behaviorism is considered a relatively new development. Actually, it contains elements of human interaction as old as the first dinner when a child was refused dessert because he didn't eat his spinach or the first father who gathered a frightened child into his arms so that they could observe a storm together. Reward and punishment, gradual acceptance of a situation, imitation of acceptable behavior—all are simplified examples of *behavior modification*, or change.

At about the same time that Freud was beginning the formulation of his psychoanalytic theory in Vienna, a Russian physiologist, Ivan Pavlov (1849-1936), reported what is called the *conditioned reflex*. The story of Pavlov's dogs, which were trained to salivate automatically at the sound of a tone which they associated with food, is a familiar one. He and his colleagues later discovered that it was possible to induce neurosis in their animals. By teaching them, through rewarding correct choices and punishing wrong ones, to differentiate between two tones or two similar figures, such as a circle and an oval, and then rendering the choices increasingly difficult by making the tones or figures more nearly alike, they confused the animals until their behavior became quite erratic. Thus it is sometimes with children. Receiving conflicting messages from parents, being taught to behave gently, honestly, and quietly while quite possibly observing that there is, apparently, a different set of rules for parents, can confuse the healthiest of children. For many it can be the path to the neurotic way.

Pavlov was hardly concerned with any philosophical application of his experiments, although, in his 80s, he began to speculate on the possible correlation between the reaction of animals to conditioned-reflex methods and of humans to the strains of ambiguities of life. The translation of his writings into English in about 1924 was exciting to clinical and experimental psychologists in England and America, especially to John Watson.

Watson (1878–1958) now found more acceptance for his learning theories and his belief, founded on his own experiments, that behavior, thinking even, results from conditioning. Best known is his "Little Albert" experiment in which he conditioned an 11-month-old boy to fear first a white rat and, later, all white, furry objects. Each time the child reached for the cuddly animal, he was violently startled by the sound of a hammer banged on a steel bar. Soon the approach of the animal elicited fear, even without an accompanying loud noise. In what has come to be known as *stimulus generalization*, the fear of the white rat soon encompassed anything which reminded the child of his fear.

Reconditioning, a basic tenet of behaviorism, is well illustrated by the now-classic account of psychologist Mary Cover Jones' 1924 work with a small child who had a terrible fear of rabbits. Using the *positive reinforcement* of food, she showed the rabbit to the child from a distance while he was enjoying a meal and, at subsequent mealtimes, brought the animal closer and closer. Gradually she was able not only to erase the fear of the rabbit but, through *generalization*, to change his dread of all animals.

Learning theories have been greatly expanded since those early days, with many prominent and dedicated people contributing to the body of knowledge. Various behavior modification techniques have been employed to help drug and alcohol abusers to conquer their habits, juvenile delinquents to redirect their lives, retardates to learn more than had previously been thought possible, and regressed psychotics to live more happily with newly acquired skills and interests. Many neurotic symptoms also have been relieved or removed through this therapeutic method.

All disciplines have their own vocabulary, and behavior modification can hardly be understood without a discussion of at least a few of its key terms:

Assertive training: instruction of patients to express both positive and negative feelings directly, honesty, and frankly

Aversion therapy: association of the unwanted, undesirable behavior with an unpleasant stimulus, for instance, alcohol with a nausea-producing drug or enema

Extinction: disappearance of a learned response when it is no longer reinforced or does not achieve the desired goal

Flooding: presentation of unpleasant, aversive stimuli intensively, either in real life or imaginary scenes, until the usual emotional response is deadened

Implosion: removal of anxiety with frequent, repeated suggestions of the dreadful possibilities inherent in the feared object or activity

Operant conditioning: shaping of behavior to achieve a desired goal or satisfy a need, thus learning new, appropriate behavior

Punishment: aversive stimulus for inappropriate behavior, such as loss of a privilege

Reciprocal inhibition: weakening an anxiety by associating the anxiety-producing stimulus with a pleasurable one, for example, associating the child's fear of rabbits with eating

Systematic desensitization: instruction in muscle relaxation followed by the construction of hierarchies, or graded series, of anxieties from the least to the most powerful, after which the patient eventually learns to relax and remain calm as each of the anxiety-provoking stimuli is presented in turn

Token economy: conditioned reinforcement in the form of tokens, credits, or points which may be exchanged for purchases, privileges, or activities, a particularly effective method in classrooms, detention or halfway houses, or wards

The major emphasis in the behavioral approach is on the here and now, with each patient receiving an individualized treatment plan, though later patients may be grouped according to symptoms. The behavior which the patient wishes to change receives the primary attention. Verbal reports by the patient play a part, and self-rating scales may be used at intervals throughout the period of treatment. Therapist, patient, and sometimes family discuss the goals of treatment openly and frankly in the beginning. Together they determine what they wish to achieve—what behavior should be modified and what should replace it—and they decide how best to measure, or evaluate, the results of any change. Frequently the patient is required to do "homework." This may consist of *satiation*, that is, repeating the undesirable thought or action over and over to the point of fatigue. Nearly always the patient is required to keep a record of progress (would-be dieters will recognize the value of this assignment).

Effective treatment using this model must stem from the friendliness and warm responsiveness of the therapist. In a climate of encouragement and reinforcement, the patient will be more comfortable in relating unpleasant, embarrassing material, and the replacements for defenses which have been painfully constructed but must be destroyed as undesirable will be more acceptable.

Humanist-Existential Therapies

The 1950s and 1960s, a period of great growth in the practice of Behavior Therapy, saw the beginning of a new therapeutic approach which, although recognizing a debt to both the psychoana-

270-937 O - 78 - 3

lytic and behavior therapies, disagrees with both in some important aspects. These *Humanistic Therapies* are based on the conviction that the psychoanalytic therapy is too pessimistic about human life and its potential and that the behavioral puts too much emphasis on measurements of stimuli and their behavioral responses. Measurements of such abstracts as creativity, love, self-expression—all of cardinal importance in this newer therapy—are indeed nearly impossible. All of them, however, have taken on deep meaning in an age seeking a greater sense of value and purpose in life.

According to this humanistic concept, every person wants to grow, to be healthy, to be a "fully functioning individual," as Carl Rogers, one of the leaders of the humanistic movement, puts it. Another term for this goal is *self-actualization*. It is also called "full humanness," in the words of the late Abraham Maslow, who viewed neurosis as a failure of personal growth. The neurotic person is seen as one who gropes ahead timidly and fearfully toward the goal of full attainment. Neurotic behavior, in other words, arises from the loss of a sense of direction in life. This loss, or distortion, comes from the confusion between one's own ideas and that of others—what we think we should do and our perception of what others think we should do. According to Carl Rogers, mental health depends upon how closely the way we think we are comes to the way we think we should be, how nearly the self comes into harmony with the ideal self. In Maslow's view, self-actualization meant that the inner self had guided the individual to the achievement of life's goal, despite problems and suffering. His expression for those moments when one is at peace with the world, satisfied with one's attainments, or feeling worthy and important, is the term "peak experiences."

Maslow's propositions have been used in nontherapeutic areas, as well, especially in business and industry, where there is increasing concern for the mental health of workers. His "Hierarchy of Needs" is often referred to as being applicable to everyone: physiology, including food, clothing, and shelter; safety or security, which may even include retirement benefits; belongingness, a sense of being important to at least one other person; self-esteem, a feeling of mattering, of having a place in the world; and, finally, self-actualization, which can be achieved only when the lower steps in the hierarchy have been realized.

Many other outstanding people have contributed to the development of this therapeutic method, which is often considered in conjunction with a movement which began a short time later, the *Existential*. Today, many therapists consider themselves *Humanist-Existential*, as Maslow is sometimes classified. In fact, many therapists of all persuasions apply Existentialist thinking. (As time goes by, more and more therapists will draw the best from

all the psychotherapies and will be ever more concerned with tailoring their approach to the particular patient's needs and personality, past history *and* future. Conversely, patients, or "clients," as Rogerians call them, will be more aware of what they want from the therapist.)

Briefly, the Existential therapists have their philosophical roots in the 19th century philosophy of Kierkegaard and of many 20th century thinkers, as well as in the works of novelists such as Sartre and Camus. The method is based on the importance of existence and the fact of death. Concerned for the emptiness of many lives and for those people who have no faith and are alienated from others, Existential Therapy stresses the special qualities of each individual life. Each person is to set his own standards, to find his own self-realization. Pain and anxiety are not necessarily to be avoided or healed, since they are, after all, a part of life. Rather, they are to be turned to good account, woven into life's fabric, and made worthwhile. In other words, death is inevitable, but really living must come first.

Many widely different therapies, with varying techniques and names, are categorized as Humanist and/or Existential. Originally, and still, in many cases, the counseling is nondirective, that is, the therapist avoids interfering with the client (so-called to get away from the connotation of sickness and helplessness in the word "patient"). The therapist does not ask direct questions or interpret reactions of the client in a judgmental way. Warmth and acceptance are the keynotes, since the assumption is, after all, that people are innately good, wishing only to enjoy richer, fuller lives—to be "self-actualized." The client, then, works toward a satisfactory self-concept in a positive atmosphere, one in which the therapist makes no demands.

Among the many spinoffs of the Humanist-Existential Therapy is Gestalt Therapy, founded by the late Frederick Perls and taking its name from the German word for "whole," or "complete." The basic idea of this therapy is that an individual must feel experiences and surroundings and the presence of others, becoming complete with the environment. Through this sort of therapy, the neurotic individual is forced out of withdrawal, with its narrow "completeness," as both therapist and patient fully express their emotions during the therapeutic encounter. Many of the newer encounter therapies reflect this scheme of exposing one's inmost feelings to others in a group.

Unlike many within the Humanist-Existential camp, *Rational Emotive Therapy* is directive, in that the therapist really forces a client to get rid of self-defeating ideas, many of which were learned in childhood. Such ideas as "nobody likes me" or "I just do everything wrong" are fallacious and promote feelings of inadequacy. This kind of thinking must be changed intellectually before self-fulfillment and satisfaction can be attained.

Another, better known example of this therapeutic model is *Reality Therapy*, which is aimed at aiding the patient to bring his or her behavior into line with the basic values which were formed early in life. Here again, the therapist directs the individual toward this goal, sometimes by pointing out the pleasurable results of having one's goals, values, and behavior in harmony with each other.

Other Therapies

Indeed, many therapeutic techniques are available. One of the newest, the *Transpersonal*, attempts to go even farther than the Humanist in expanding individual awareness, so that the "higher self" truly has a feeling of becoming a part of the universe. This therapy may, through meditation, variants of Yoga training, or training in the control of the imagination, thoughts, emotions, and desires, assist in developing spiritual growth and increasing a greater use of one's aptitudes and previously unrealized, hidden strengths.

Recent years have seen a surge of *growth* groups, all with the purpose of self-fulfillment, awareness of one's self and of others, and finding meaning in today's society. Most of these groups are familiar—sensory-awareness, T-group, or encounter group—and they may be offshoots of any of the therapeutic models, or a combination of them. They have the advantage of being less expensive and of helping individuals to talk to each other and to express their concerns, both their own and for others in the group. Participants can tell each other "where it hurts" and what problems they have. Learning to share in this way is beneficial to many—they are able to unbend with someone else and to try to help another person with a burden.

Not everyone can stand such exposure, however. Depending on the skill and dedication of their leaders, these groups have been successful experiences for many. For others, the results have been poor, and for a few, disastrous, reinforcing the dictum that both therapist and therapy must be chosen with care.

Types of Neurotic Disorder

Final answers to the causes and the best treatment of neurotic disorder may never come. Certainly it is apparent that there is no one therapy any more than there is one single cause. This discussion of how the various therapists view the neurotic disorder and a closer look at each of the major neurotic types, their similarities and differences, as well as at a few of the treatment methods, may be helpful in achieving a better understanding of both neurotic and normal responses to life.

It is difficult to identify *anxiety neurosis*, to distinguish it from the occasional anxiety common to everyone, from fear reactions associated with phobic neurosis, and especially from anxiety as one of the symptoms found in the other neuroses. The key word might be "specific." Anxiety over a coming event, with worry about handling oneself well or concern about the outcome, is certainly not unusual. An interview, an examination, a party, a date with someone new—the list of anxiety-provoking situations in ordinary life is nearly infinite. Indeed, most people worry unnecessarily, the most futile exercise of all being to worry after the fact, after the deed is done, or the wrong word is spoken.

Fortunately, most people recover from these temporary tribulations. "Oh, well, that's life" or "better luck next time" might be typical responses for bouncing back from such anxiousness. Sufferers from anxiety neurosis, on the other hand, are surrounded with a cloud of anxiety, nonspecific, subjective, pervasive. Free-floating anxiety is a common, and very apt, description for this aura that hovers, for no apparent reason, so that even minor crises precipitate strong feelings of dread. When the acute worry or fear appears suddenly, for no logical reason, it is called an "anxiety attack," whereas an "anxiety reaction" is the term when such feelings of dread linger long after the upsetting event or fearful encounter is over and done. Unlike a phobic reaction, in which the anxiety has become focused on a specific object or situation—dogs, elevators, crowds—the neurotic anxiety response may have no particular reason for its onslaught.

"Butterflies" before performing in a recital or giving a speech, a queasy stomach before a date, or clammy hands before a job interview—who has not experienced such discomfort? Feelings like these have their place, since they indicate the hormonal reaction which excites or arouses the body to put forth the energy necessary for accomplishment, for excelling in the situation.

Similar sensations don't seem to help the coping responses of the anxiety neurotic person, who may be convinced that he's dying, after experiencing the frightening tremors, palpitations of the heart, and rapid or shallow breathing which are symptomatic of this syndrome. And if these begin with no apparent reason, there is the constant dread that they will begin again. The tendency to breathe rapidly and heavily, a condition known as hyperventilation, is especially unsettling. Many physicians may be able to detect the real reason for it and to explain it to the patient's satisfaction; others may believe, from the evidence, that there is the possibility of heart involvement and recommend additional tests, so that the patient is further alarmed.

Most anxiety neurotics live fairly productive lives, with little likelihood that they will develop other stress-related complaints or

psychotic impairment. Nor is their life span shortened because of this neurosis, which usually begins when they are in their twenties.

This most common of the psychiatric syndromes knows no social, economic, or educational level. Some investigators into the problem believe that there may be some as yet unknown, or at least unproved, reason for the difference between anxiety neurotics and normal individuals, possibly a biochemical basis. The difference may be caused by the understandable apprehension and inactivity of the neurotic person. In any case, it does seem to run in families, and there is the suggestion that, in men, alcoholism may mask the condition, accounting, at least partially, for the statistical finding that twice as many women as men are affected.

Many psychotherapists have attempted to give a rationale for this irrational, subjective fear and dread. Freud called it the fundamental problem of neurosis. He came to believe that it occurred because the ego repressed dangerous impulses when anxiety arose in a dangerous situation. Adler was convinced that feelings of inferiority caused anxiety, while Jung came to the conclusion that people feared awareness of themselves. According to the Neo-Freudians, there is internalized conflict, breakdown of defense mechanisms, and disturbance of interpersonal relationships. Later, this view was expanded to mean a threat to the security of the personality.

Predictably, the Existential thinking considers the neurotic as one who sees no purpose or meaning in life. Dread comes because of a conflict in values and because there seems to be no answer for spiritual problems which arise. Maslow saw the condition as a fixation in safety needs, which holds the individual back from the achievement of real self-hood. The anxiety neurotic is limited in his acceptance of reality and, by protecting himself with all his little defenses, is unable to live fully.

Fortunately, most cases of anxiety neurosis are mild and rarely lead to hospitalization. In fact, they often remit, or go away, to return with decreasing frequency, or never. Encouragement and reassurance, whether furnished by a general practitioner or a psychotherapist, an interested friend or pastor, are often the best and only treatment required. Sedatives are often prescribed and can be of help, but only mild tranquilizers are advised.

Desensitization is occasionally employed, the mildest anxiety-provoking idea or stimulus introduced first, followed by increasingly disturbing stimuli; or flooding, presenting the most alarming possibilities to arouse a simulated anxiety, may be the treatment of choice. There are cases, too, which have been successfully treated with assertiveness training, the object being to raise the individual's own self-evaluation.

Depersonalization

Everyone has had brief, occasional Alice-in-Wonderland sensations. Time may seem to stop or to advance at erratic speeds; the body may seem to be floating, to be larger than anything around it, or to have become, suddenly, indefensibly small; one's immediate world may look alien and menacing, with familiar things changed in shape and color. Among persons with no history of mental or emotional trouble, this *depersonalization* may occur when an individual is half asleep, utterly exhausted, or under the influence of drugs.

Depersonalization, defined as feelings of strangeness and unreality concerning the self or the environment, has only recently been added to the lexicon of neuroses as a separate syndrome. It is now considered not only an occasional symptom, in other neurotic states but, sometimes, a separate diagnostic condition. It is also frequently recognized in certain physical or psychotic situations, such as the early stages of schizophrenia or in temporal lobe epilepsy.

There may be a sensation of change involving both the inner and outer worlds and an uncomfortable feeling of insubstantiality. Physically, bodily perceptions are of deadness, hollowness, or detachment. Psychically, sheer fright is an understandable reaction; incapacity to feel any emotion is another. The syndrome may appear in conjunction with anxiety and certain phobic states such as agoraphobia or extreme shyness. It has been particularly noted among disturbed young adults, some of whom suffered from a badly warped sense of time and a belief that the world was coming to an end.

Interestingly, clinicians are observing that neurotic depersonalization can be a decompensation and defense which some individuals unconsciously establish against an incipient psychotic condition, or it may occur during therapy for other syndromes as part of the getting-well process. In fact, it may be a temporary evasion of and resistance to the whole therapeutic activity. If so, it is recommended that the therapy continue in the very same direction which has produced the depersonalization. Some therapists suggest self-actualization as the treatment of choice for this neurotic syndrome. For persistent episodes, all advise therapy in a specialist clinic.

Depression

"Am I blue?" So went the old song. Blue because his "baby done left him," the singer was voicing a perfectly valid reason for feeling low. Abandonment, bereavement, discouragement, or failure are all triggers for a melancholy mood. It's easy to list many obvious "blues-makers"—a succession of cloudy days, the fatigue from too

270-937 O - 78 - 4

much work and too little time, or a "let-down" after an exciting trip or joyful holiday.

When the mood drags on and becomes more pronounced than the normal ups and downs of daily living warrant, it is called *depression*. This disorder, in all its forms, has probably been more discussed, researched, and written about than any other. The "loathed melancholy," invited "hence" by the poet John Milton, received its name from the ancient Greeks. They saw depression as too much "melan chole," or "black bile," one of the four "humors," or bodily substances which they believed controlled the body and brain. There have been periods in history—eras of national growth and optimism, in fact—such as the Age of Elizabeth I in England, when the attitude of melancholy, either real or affected, was considered acceptable, even stylish. Indeed, there is a large body of literature within Western culture which was produced during bouts of deep depression. Familiar, too, is the history of intermittent depression suffered by such eminent people as Abraham Lincoln, Winston Churchill, Sigmund Freud, and, most recently, Edwin ("Buzz") Aldrin.

With good reason depression has been called the mental illness of the 1970s. The National Institute of Mental Health has estimated that 4 to 8 million Americans suffer so severely from depression that they are unable to maintain their normal activities or must seek therapy, while 10 to 15 million more are mildly affected, probably not to the point of serious disruption of their lives, but certainly to the extent of much unhappiness to themselves and their families.

It is estimated, also, that about twice as many women as men are afflicted with this disorder, although some diagnosticians feel that alcoholism among men may actually be a manifestation of depression. This vast difference has raised another question for therapists and researchers alike: Can it be explained, in large part, at least, by women's social and economic status and the learned-helplessness role, as some researchers believe, or are there genetic and hormonal reasons for the difference? There are a number of researchers, some of them funded by NIMH, who are looking for answers and, hence, relief for the symptoms of depression.

For many people, depression is serious enough to be life threatening. Suicide and depression have an alarming correlation—not all persons who attempt suicide are depressed, nor do all those suffering from depressive illness seek this way out, far from it. But about 75 percent of those who attempt suicide are seriously depressed.

The millions of Americans who can't seem to snap out of it, who remain downhearted and troubled for longer periods than the average expectancy or for whom grief has become a way of life, may be suffering from one of several types of depression, for one

or a number of causes. There is the depression which may accompany a physical illness, a natural phenomenon which should disappear when the body rights itself. (Therapists nearly always require a patient to have a thorough physical examination at the very beginning of treatment.)

Bouts of depression are sometimes a short-lived accompaniment to bodily changes or cyclical events, such as menstruation. *Postpartum depression*, or "after-baby blues," is nothing unusual or fearful—unless its condition lingers or renders the mother (and father, indirectly) unable to care for and enjoy the new child. Certainly, reaction to change in body and appearance, sleepless nights, and realization of a new, awesome responsibility may well combine to elicit a few temporary mood changes.

The most common bodily cycle, growing old, is often accompanied by depression—not everyone agrees with the poet Robert Browning that "the best is yet to be." In some individuals, there is no marked reaction to the aging process, while for others, the response to disturbances of metabolism or glandular function may bring about serious signs of trouble, with such depressive symptoms as insomnia, excessive anxiety, worry, and physical complaints such as dizziness, headaches, and overtiredness. This has been called *involutional depression*, or *involutional melancholia*. It usually appears in women around the ages of 45 to 55, and in men around 50 to 65. (Authorities have differed as to whether the condition is unique to this age group or may be psychotic depression, the more current view.)

Many individuals who have remained unaffected by this involutional syndrome become depressed in later years. Retirement, loss of a spouse, and financial worries frequently trigger depression in the middle-aged and elderly. The dread of no longer being needed at the job which has occupied much of one's thoughts and time or at home—glibly called the "empty-nest syndrome"—can be devastating. Fortunate is the man or woman whose physical and mental health complement each other, or work in tandem, so to speak; who may find another position, paid or volunteer, or who contentedly finds this time to be an opportunity for new learning or service experiences or for the enjoyment of books and hobbies for which there was never enough time before.

Of course for many, recovery from grief and loss may take quite a while. This period should not be overly prolonged, nor should it be hurried or postponed. The therapeutic term, "working through grief," is apt, since it implies gradually leaving the grief behind and, at least partially, filling the void with other, positive interests.

Because depression may be exhibited occasionally by everyone, from childhood through old age, and because it may accompany physical illness and transitory stress, it is easier to describe than to classify. What's more, two of the major *affective*, or emotional, disorders are known principally by their depressive symptoms. The

first of these, *bipolar*, or *manic-depression*, alternates between moods of excitement and of lethargy and withdrawal. The "up" period may be one of euphoria and elation and frequently of feelings of near-omnipotence, but not necessarily of happiness, certainly not of contentment. The "down" period is just that. Changes between the two are signaled by changes in body cycles—rhythms of sleep, energy, even temperature.

The other affective disorder, known as *unipolar*, lacks the manic swings. Both of these forms of depression are *psychotic*, whereas *neurotic* or *reactive depression* does not indicate loss of touch with reality and is not nearly as disruptive and destructive a psychological disturbance. Further, *psychotic depression* may appear for no reason that is readily apparent to the outsider, while *neurotic depression* can often be tied to a fairly specific event, even though the occasion for the depressed response may not be as obvious as that which follows a normal reaction to grief.

In the *reactive depression*, there may well be, also, a history of other neurotic manifestations in the individual and in other members of the family. And in contrast to persons suffering from other neuroses, the *depressive neurotic* seems more likely to respond to stress or grief with self-accusations and guilt, and often to be rather insecure and passive, oversensitive, and inclined to harbor rather than to express anger and resentment, so that his depressed mood seems to be out of proportion to its cause.

Most neurotic depressives make their condition evident in their constant boredom and inactivity, tiredness, and lack of interest in activities which formerly brought enjoyment. They may be irritable, forgetful, cranky about minor annoyances, indecisive, and slow to react. They may cry a lot and have little appetite for food or sex, with physical complaints ranging from indigestion and constipation through insomnia or disturbed sleep to headaches, dizziness, and abnormal heartrates. Many may unconsciously hide their depression from themselves and others with overdrinking, overeating, or overworking, or with promiscuity or gambling, activities which may also be a means of seeking relief from melancholy. (Since alcohol is itself a depressant, since overeating and overworking may lead to physical impairment, and since promiscuity and gambling may lead to feelings of guilt, the relief is likely to lead in a circle right back to further depression, exacerbating rather than solving the problem.)

For most cases of the "blues," the cures are as obvious as the causes, and the greatest of these is time—to rest, to lick one's wounds, and to regain perspective, alone or with a sympathetic other. From friends, physicians, and advice columnists come all manner of suggestions, nearly all of them effective: change of scene or of tasks, like making a new dress instead of cleaning the closets, or chopping wood instead of cleaning out the basement; giving oneself a special treat (according to cartoons, a new hat is the tradi-

tional mood elevator for women); looking up friends who are especially congenial; taking time out just for oneself; or helping someone else.

Ideas of this sort are splendid for anyone who is down in the dumps. Indeed, one woman who called the National Institute of Mental Health's Public Inquiries office for advice in finding therapy for her depression evidenced the beginning of recovery when she said, "I think I'd feel better if I got out and did something for somebody else."

However, to most people in the midst of a depressive episode, whether neurotic or psychotic, such suggestions would seem flippant and uncaring, cruel, even. Such remedies probably seem like just too much trouble to the individual in a mild depression, feeling low about the present and pessimistic about the future, unable or unwilling to deal with the day-to-day business of living. They would certainly be unwelcome to the severely depressed, the person who is completely withdrawn and apathetic, until time and therapy have done part of the recovery work.

Periods of moderate depression, signified by slowed thinking and action, are considered by some to be the most dangerous because suicide is likely—self-guilt is especially strong among this group, and they are able to muster enough energy to generate at least a suicidal attempt as a solution to their problems. Usually there are warning signs, aptly and poignantly called "cries for help." Occasionally the despondent mood may appear to lift or disappear immediately preceding the act of suicide, evidencing the individual's relief at finding a way out. Unfortunately, conventional therapy doesn't always work, and constant vigilance by concerned others is not always possible.

But the outlook for people suffering from neurotic depression is bright. Most people, whether they are involved in mental health service or not, are becoming more informed about the nature of depression of all sorts. There is not such surprise as formerly that some men and women—and young people—are depressed rather than exhilarated by Christmas or Hannukah, times of giving and merriment, or by the beauty and promise of spring, seeming rather to identify with a cold November.

It is known, too, that most mild depressions nearly always disappear without treatment and that usually they do not recur—they just have to be lived through. For more serious cases, therapy of some sort is required, sometimes for only a short period. Therapy can be achieved through the administration of antidepressant drugs (physician-prescribed, of course), the use of electroconvulsive shock treatments, a talking therapy, or a combination of these. No matter which therapy or combination of therapies is used, it is important —more important than many realize—that treatment be continued past the point of feeling a little better to the point of assurance by both patient and therapist that the desired recovery is well on the

way. Meanwhile, medications can be lessened in strength and other types of treatment in frequency, until the patient can stand on his own.

During an episode of neurotic depression, psychotherapy may be used which can help the patient to uncover the emotional backgrounds of distress and to change personality and living patterns so that the recurrence of depressions is less likely. Supportive group therapy, listening and being listened to, making and accepting suggestions, is beneficial for some individuals.

A new therapy is being tried in Philadelphia with good results—about 80 percent—although its chief practitioner, Dr. Aaron Beck, director of the Mood Clinic at the University of Pennsylvania Hospital wants to do followups for a few more years before making great claims for his style of treatment. This *cognitive therapy*, as it is called, seems so sensible and old-fashioned that new may seem to be the wrong adjective.

The idea is to help change thinking about oneself and one's world, so that the individual will recognize incorrect automatic reactions and view them objectively. In this way, a negative thought—I'm wicked and unworthy of anything good, the world is a terrible place, things can't get any better—can be put aside before it becomes depressing. The therapist collaborates with the patient rather than playing God, dealing with symptoms and behavior rather than digging into the unconscious.

Dr. Beck sometimes suggests talking to oneself: "I've prepared dinner (made a good sale, passed an exam) many times before, so why should I not be able to do it now?" The patient may be required to keep a journal of activities and the good or bad feelings which accompanied each event. Going over such a list can be illuminating for the patient who may have viewed reactions in a negative way, whereas the doctor or someone close to the patient can point out positive accomplishments and pleasant experiences.

Therapists are eager for depressed persons to know what they know, that depression is not hopeless, that if they wait awhile, it will probably go away. If it lingers too long, or recurs too soon or too frequently, there are many resources for help.

Hypochondria

Maintaining good health is a valid concern. Exercise, cleanliness, sufficient rest, and good medical attention are all obvious requisites. These and the informed use of sound nutrition are sufficient to provide for most people the sound body which, since ancient times, has been deemed basic for a sound mind. Nor should such practice require much time and effort—or thought—if good habits are formed.

There are individuals, however—perhaps 5 percent of those classified as neurotic—for whom these concerns become such a

preoccupation that they form a way of life. In *hypochondriacal neurosis*, complaints about constipation, pains in the heart, head, stomach, or back, or perhaps of symptoms proving the presence of some awful and preferably rare disease consume a good part of one's time and attention and unfortunately, conversation. The hypochondriac eagerly reads about new diseases and tries new medications, with little real knowledge of medical pathology. She (more commonly the hypochondriac is female) is likely to use a wide range of medications with little discrimination and, when describing her condition, to present not one but many symptoms.

Few hypochondriacs are actually physically unhealthy. As in the *hysterical* neuroses, they do not show anxiety which might reasonably be expected of the outcomes of such dreadful illnesses as they describe. Unlike *conversion hysterics*, however, they do not exhibit such sensory, motor, or visceral symptoms as paralysis or anesthesia. And as might be expected, a real organic illness, *with* hypochondria, grows in the patient's mind until it is magnified far beyond reality.

A hypochondriac can really ruin a family outing. Suddenly Mom, following a fairly predictable pattern, "doesn't feel up to it." Other family members may go on but their good time will be tarnished by guilt feelings for having left her alone or by dread of the recital of woes they will have to listen to on their return. While there may be a strong belief that she is actually quite well, those close to her will hesitate to disregard her complaints completely. (It is unfortunate that sometimes persons of normal psychic energy may push themselves beyond their physical energy to avoid any inconvenience to others or an appearance of hypochondria.)

How does hypochondria come about? Its example in a parent or other close relative is a good start, as is overconcern with childhood illnesses, beyond the normal precautions. The pleasurable sensations of receiving added parental attention, a visit by the doctor, and sympathy from friends and siblings naturally help to mitigate the discomfort of an illness. This reaction is proper and right. It may lead to future trouble, though, if the patient learns to use illness as a way of controlling those around him and of avoiding distressful situations.

Many cases of hypochondria begin in middle life. A far greater impetus to the development of this condition than the normal physical difficulties which may accompany aging is the disappointment of realizing that one's life has not, and probably now will not, achieve what one had hoped. Discontent with one's marriage, occupational outlook, or social situation may trigger hypochondria in the predisposed person as a response and a retreat. If one is sick, one doesn't have to try. She receives sympathy as a substitute for love, with no active effort on her part. And if genuine disability is exacerbated by hypochondria, the individual may not try to learn

to cope with his disability or to compensate for it through more normal, healthy means.

Since the hypochondriac is not consciously malingering and truly believes she is not well, treatment is difficult. Indeed the therapist who, after a thorough examination or physical report of the patient, indicates disbelief in the seriousness of the condition will probably lose the patient to someone else. It is possible and certainly to be hoped that some behavior-modification methods may be effective or that the patient may become convinced through therapy that approaching life squarely will be healthy and self-fulfilling rather than, ultimately, self-defeating.

Hysteria

The neurosis known as *hysteria* can appear in many forms. Sometimes it mimics physical disabilities—a lame leg, writer's cramp, deafness, or loss of sensation. Occasionally it is hysteria that accounts for a blocking out of one's identity and past, or of running away and starting a new life with no memory of former ties and responsibilities. Also, there are a few instances of two or more personalities, each of them a complete entity within the same body, which may be attributed to this disorder.

Fiction, cinema, and television have found situations based on such real-life examples a rich lode indeed. Who has not seen a story about a singer who, when her big moment finally arrives, unaccountably loses her voice, or a show about the victim of a crime who, for no apparent physical reason, is struck deaf or blind? And the husband who suddenly remembers his identity after years of wandering and returns to his family, sometimes to his wife's consternation, is superlative material. Gothic novels are replete with sleepwalkers, roaming unaware through dark corridors with eyes wide-open and arms outstretched. Also, people remember the absorbing book, later a film, *The Three Faces of Eve*, which recounts a true story about multiple personality.

The frequency with which various models of hysterical neurosis have been dramatized, and the impact of newspaper accounts of forlorn individuals found homeless and penniless in a bus station with no idea of who they are or where they came from, far outweigh statistical reality. It is estimated that less than 10 percent of all neuroses which are treated may properly be called hysteria. The condition is by no means an exclusively female disorder, as the ancient Greeks believed, although more women than men are so classified; social and cultural factors may well have dictated this pattern as more appropriate to women than men, as with some of the other neurotic patterns.

Long before Hippocrates, hysteria was recognized as an individual and, on occasion, a group phenomenon. Mass hysteria has

occurred from time to time, for instance in the wild outbreaks known as St. Vitus' Dance during the Middle Ages. In more recent times, there have been reports of seizures of entire assemblages of people in a schoolroom, an industrial plant, or a religious gathering, with all of them exhibiting the same symptoms of a reaction which spread from one to the other by the power of suggestion.

The study of hysteria and its treatment, first with hypnosis and later through psychoanalysis, was an opening wedge in the 19th century's inquiries into the neuroses. In fact, the first significant publication of the psychoanalytic school was *Studies in Hysteria*, by Drs. Sigmund Freud and Josef Breuer. (Interestingly, Freud's theory that the hysterical symptoms evidenced in physical disabilities or illness are actually "conversions" of sexual needs and conflicts is reminiscent of Hippocrates' theory of the "wandering womb.") Pierre Janet, a fellow-student of Freud's when he studied under Dr. Charcot in Paris, is deemed the first to give a psychological theory of neurosis. He considered it a constitutional weakness of the nervous system and blamed hysteria on poor heredity and degeneracy. His therapy, however, was a forerunner of both psychotherapeutic and behavioral therapies.

Therapists now know that the emergence of hysterical reactions may be impelled not only by sexual problems but also by avoidance of painful duties or increasingly demanding, uncomfortable responsibilities, by escape from stressful or painful memories or prospects, or even by distrust of one's own motives and desires. Hysteria resembles other neurotic patterns in these respects and in its use of the repression of undesirable thoughts and impulses. Obviously, dealing with a conflict by forgetting it (avoiding it), if successful in early life, can easily turn into a habit, with repression as the chosen method of handling crises in later life.

Hysterical neurosis has certain similarities also to the *hysterical personality* disorder. This disorder is a paradox because its effective result is a relatively firm control of interpersonal relationships, even though its basic message is one of frailty and helplessness. The hysterical mode may be forming when one begins in childhood to view the world unrealistically, without the ability to weigh facts and to make critical judgments for oneself. According to many therapists, these ingredients mixed with (or because of) insufficient proportions of love and attention in the early years are the recipe for the hysterical personality. It is axiomatic that low self-regard can result from receiving loving parental attention only when one is sick or playing a role. The other concomitant of the hysterical personality, a feeling of worthlessness and inadequacy, follows logically.

Such descriptive terms as emotional, histrionic, unrealistic, or incurably romantic are applicable to both groups. Both are unaware that they are over-reacting. Some current therapists have observed that the two, the hysterical personality disorder and

hysterical neurosis, are akin in yet another respect—the unconscious but pervasive obduracy and self-will evidenced in both, a vestige of Janet's comment about the hysteric's fixed, though subconscious, ideas. In the hysterical personality disorder, this control is exercised over one's responses from others. The self-will is seen as a prime factor in *conversion reactions*, historically the more familiar of the hysterical neuroses.

Conversion reaction is the hysterical imitation of physical symptoms. It appears in sensory symptoms such as analgesia, a loss of sensitivity to pain; anesthesia, a loss of all feeling in some part of the body; or paresthesia, strange, tingling sensations. Sometimes the conversion emerges in motor symptoms—*paralysis* of an arm or leg, or in mutism, deafness, or blindness. *Visceral symptoms*—headache, choking sensations, or persistent hiccoughing or sneezing—are another possible response of the conversion type.

New knowledge about the extraordinary ability of an individual to control bodily functions—blood pressure, migraine headaches, possibly even some epileptic seizures—has aroused great interest recently among scientists and lay persons alike. Awareness of this ability renders more comprehensible the unconscious power of the conversion hysteric to blot from sight what he does not wish to see, to immobilize a limb he does not wish to move, or to be deaf to what he does not wish to hear. Cases of paralysis of a hand which had injured someone or of deafness to prevent hearing of a loved one's death are typical conversion reactions.

Interesting observations of conversion reactions were made during both World Wars among some of the military personnel who reported for "sick call." A soldier who suffered from such a stiff back that he could not straighten up, or a gunner with tremors or paralysis in his "shooting arm;" an airman who complained of night-blindness (if he flew night missions), or his buddy who suffered from blurred or double vision; sailors seized with deafness, trouble in breathing, or aphonia, in which they could not speak above a whisper—all these illustrate ways of handling stressful situations unconsciously, without having to admit to fear or failure, and without damage to self-esteem.

With the passing years, there have been many changes in the types of conversion reactions as medical discoveries made many illnesses easier to diagnose and new treatments made some disabilities more rare. Certain characteristics remain, however. The hysteric is still viewed as histrionic, manipulative, unconcerned about his disability, demanding, dishonest, and usually unaware of the depth of his self-centeredness. The female hysteric is seen as sexually provocative but frigid and basically rejecting and, like most hysterics, possessing a low sense of self-worth.

Fewer dramatic sensory or motor types of hysterical neuroses are appearing at present, especially among better educated persons; however, simulations of the more unusual diseases, difficult

to diagnose and treat even when they are real, are cropping up. There have also been cases of hysterical appendicitis or tuberculosis, even pregnancy, with many of the presenting symptoms to lend authenticity. Inspiration for these comes, of course, from the illnesses of friends or relatives (or television).

Despite the striking similarity of hysterical pseudodiseases to the real thing, skilled diagnosticians can usually spot the hysterical disturbance. For one thing, the hysteric shows little concern about his disability or its possible long-term consequences. For another, the disability does not follow the expected pattern—a paralyzed leg or arm does not wither from muscular disuse, the hysterically blind person does not bump into things, and muscles contracted into writer's cramp or a locked knee usually relax during sleep, sometimes remaining relaxed for a while if the person is awakened suddenly. Most illustrative are the once-familiar "glove" and "stocking" anesthesias, in which the lack of feeling extended in a pattern that would fit a garment rather than the actual system of nerves.

The distinction between conversion reactions and real organic disorders may be blurred when there has been a genuine disorder prior to the onset of its hysterical counterpart. Diagnosis can be difficult, too, in the case of a victim of an industrial or automobile accident who may see his condition as proving beneficial financially. However, such malingerers react differently from the true hysteric in their defensive responses to inquiries or sympathy, being surly and evasive rather than typically open, dramatic, and unconcerned when discussing their symptoms.

Feeling sick at the prospect of an unpleasant event or another day with a teacher or a boss one dislikes is not unusual, nor is it unheard of to avoid facing a problem by claiming illness. Most people could plead guilty to this occasionally. The conversion hysteric, however, comes finally to employ this means of avoiding even everyday vexations which most of us handle with an all-in-the-day's-work attitude, perhaps with some grumbling or a similar tension-reducing mechanism.

Many people, at times of emotional shock—loss of a spouse, extreme financial reversal, or an accident—undergo temporary periods of unreality, giving the impression of being dazed. An overload of stimuli or of things one thinks must be done all at once may result in brief lapses of conscious activity. At such times, pausing awhile to pull oneself together is wise and salutary. Scarlett O'Hara's way of handling reversals, "I'll think about that tomorrow," works well for many people. Waiting until things are quiet or until one is rested, when the first shock is dissipated, is useful for gaining perspective and regaining calm.

The less stable personality, however, who has not learned to cope with extraordinary demands on his psychic resources has little protection from the results of anxiety and, as in conversion reac-

tions, may use repression of anxious thoughts and rejection of reality to an extreme degree. As stress mounts and unpleasant memories pile up, or as guilty, unworthy wishes and actions multiply, the individual seeks escape. Few people, though, envision themselves as so cowardly as to run away. One way out is repression, conscious or unconscious. With the unconscious repression comes repression of large parts of the personality. The more agreeable portions will continue to function in the usual way, since only the unbearable or threatening matter is considered undesirable. This is the *dissociative reaction.*

This dissociation between parts of the whole person, when it results in total or partial loss of memory for one's identity and past life, is called *amnesia.* Cases of physiological amnesia occur from time to time from brain injury or diseases of the nervous system or in certain disorders of the aging; in these instances, information stored in the memory is truly lost.

Further avoidance of problems, not only by forgetting but by running away, physically escaping, is known as a *fugue state.* Occasionally, though not invariably, the individual who has thus escaped may, after days or even years, wake up and realize that he is not where he belongs, having complete amnesia for the events of his fugue experience. In the meantime, he may have, quite literally, started a new life with no conscious recollection of the old. Interestingly, during the fugue, his habits, ethical values, talents, and interests will probably remain the same. His activities, though, may well reflect some wish fulfillment in the new identity he assumes, showing an unconscious choice of new patterns melded with the old.

The dissociative reaction can show up also in *somnambulism,* or sleepwalking, although some cases may be due to a neurological abnormality. Characteristic symptoms of this syndrome, which seems to occur more often in boys and men, are walking or performing ritualistic behavior apparently with great purpose even though in a dreamlike trance; responsiveness to questions and commands; and an amnesiac condition for the sleepwalking period upon awaking. Children frequently outgrow the condition, which may be accompanied by night terrors and bedwetting. Since the sleepwalker may come to harm or, occasionally, do harm to someone else, therapy, physical or psychological or a combination, is warranted.

The sayings, "I'm just not myself today" or "I didn't think you had it in you," reflect ordinary reactions to normal variations in personality. A wish to be more easygoing or more vivacious, a regret over misbehavior, a desire to appear more composed—all of these are occasional, but very predictable, responses in life. And everyone gives way sometimes, usually with more surprise to others than detriment to himself. The dramatic, fortunately rare, cases of *dual* or *multiple personality* illustrate a hysterical han-

dling of this sort of eruption of unwelcome thoughts and impulses into the consciousness.

This multiple personality change appears to be wrought in two complete beings or more, rather than composed of fragments of the previous personality as in the case of the amnesiac. And, unlike the victims of amnesia, the two or more personalities housed in the same body usually have quite different value systems and mannerisms—prudish vs. promiscuous, animated vs. quiet and reserved, neat vs. unkempt. Seemingly, the one must compensate, or perhaps atone, for the other. These complete switches in personality, leading to disparate preferences in clothing, companions, even speech, may take place in only a moment or two, in some instances without either personality being aware of the other. More difficult to comprehend are cases where, although the dominant personality is not conscious of the other, the "co-conscious" personality in some way, such as automatic writing, indicates an awareness of the thoughts and activities of the dominant one, if only to jeer.

Such classic forms of hysterical reactions, conversion *or* dissociative, may not be encountered as frequently as formerly. As with phobic and other neuroses, styles do change. Parenthetically, it might be conjectured that some of the young persons who suddenly abandon jobs or schooling to embrace a new cult or "follow the guru," certainly a more appealing method of avoidance than most of the hysterical reactions mentioned above, may have more in common with the so-called "sofa ladies" of former days than they might realize. These were the women who, after a lover was killed in battle or the family fortunes declined, "took to their beds," to be nurtured for the rest of their long lives by their families and visited by sympathetic friends on their Sunday afternoon rounds.

"Curing" the hysterical neurosis can be difficult. Sometimes, of course, spontaneous remission will occur. The stressful situation which prompted onset of the condition may subside or disappear or, through the intervention of a helpful friend, the family physician or a clergyman, the sufferer may be led to a change in living and thinking which will alleviate the stress or ease adaptation to it through more normal avenues. A person may be prompted to return from a *fugue state* when faced with even more distasteful problems than he fled from originally. Usually, however, it is advisable to seek therapy.

There are certain techniques, hypnosis and drug therapy, which have been used for many years and which are found helpful in the treatment of specific reactions—amnesia, paralysis, hysterical deafness, and so on. Many therapists question, however, whether removing specific symptoms is sufficient. They wonder whether the hysteric response to avoidance may not re-emerge in some other form.

Therapists who hold this opinion view their objective in treating the victim of hysterical neurosis as seeing that the patient's symp-

toms no longer work. A familiar lifestyle, comfortable or uncomfortable, is likely to remain if it seems to work even passably. After all, it is human to resist relinquishing a cherished concept or changing an ingrained habit of thought or action. Therefore, a pattern of sickness as a response to life's challenges or of repression and forgetting as an escape must be altered.

The client must truly want to make the change—a requisite for successful therapy in any neurotic or personality disorder. The therapist can allow none of the usual ploys of the hysterical neurotic, be it dishonesty about family relationships or past motivations, histrionics or exaggeration, seductiveness, or shifting of blame. The initial focus of treatment may be on removal of the reported symptom, so that immediate relief can be obtained and the chronic pattern of sickness as a response can be broken. The final objective is much more difficult. That aim is to change the client's pattern of living and to force him to take full responsibility for what happens in the future, with no attempts at the old defensive patterns.

Neurasthenia

"Tired nerves" sounds like a television commercial. Actually, it was Freud's definition of *neurasthenia*, literally "nerve weakness." After Beard and others used the term, it became a late 19th and early 20th century catchall explanation of many neurotic symptoms, as nervous exhaustion and nervous breakdown are now. The cure was a long period of rest and relaxation, since it was believed that the cause was too much work and stress. Indeed, Freud considered the United States the natural habitat for the neurasthenic because of its frenetic life-style.

Overwork, of course, results in physical rather than nervous exhaustion. But the chronic fatigue, sleepiness, lack of enthusiasm, and inability to concentrate and complete a task which are symptomatic of the neurasthenic are comparable to the sensations of boredom, frustration, or disappointment which can occasionally turn a sunny day gray for anyone. And just as the lethargic feeling can be alleviated in the average person by going swimming or dancing or to a movie, so it is in neurasthenics, who usually rally noticeably, if only temporarily, with attention and diversion.

It is roughly estimated that neurasthenia comprises about 10 percent of all neuroses. Like them, it contains elements of prolonged, probably unconscious emotional struggles. Its sufferers are sincere in their complaints, and its effects are a diminution of the enjoyment of living. Additionally, families, particularly spouses, are held down by the weakness and weariness of neurasthenic persons, whose basic deficiencies are lack of self-confidence and independence and whose history may include a sickly and over-

protected childhood. The condition differs from hypochondria, since it consists of general complaints of weakness and lassitude, with vague aches and pains.

The neurasthenic is understandably hard to treat, sometimes even welcomes the discovery of a real somatic disturbance which will justify the chronic litany of complaints. Possibly there is a self-defeating factor against recovery in that eventually the dreariness of the neurasthenic person will lose for that person the necessary and desirable patience and support of family and friends. Further, there is the distinct possibility that genuine physical disorders may result from the lack of physical exertion, good appetite, and mental alertness which are important to good health.

Some of the unhappiness and anxiety can be relieved by the use of tranquilizing drugs. Permanent therapeutic results, however, depend on the promotion of understanding and self-confidence—in other words, the development of maturity and courage toward life.

Obsessive Compulsive Neurosis

The fabric of everyday life contains many strands from games children play, ritual observances, old wives' tales, and proverbs based on the experience of many generations. Only rarely, were we to pause and look closely at this tightly woven fabric, would we notice these different threads unless there were knots or holes or an unpleasing predominance of an inharmonious color.

"Step on a crack, you break your mother's back." Children hop and run from one concrete block to the next, happily calling out to each other on their way home from school. They stare in amazement at the old man from down the street who touches every fifth fencepost and every other lightpole, in unvarying order, when he takes his evening walk.

"Knock on wood." Nearly everyone participates in such little rituals. We cross our fingers to ward off bad luck (or to atone for telling a fib). We knock on wood to ward off the bad luck which might come from bragging. Because of habit or custom or old superstitions, we perform these small rites even though we feel a bit foolish doing so. But checking a prescribed number of times on the arrangement of the kitchen cannisters in order to alleviate anxious feelings seems alien and unnecessary.

With good reason and the wisdom of experience, grandmothers adjure the young: "Look before you leap." Deciding on a major, a career, a spouse, a divorce, a new house, or a new car should be accomplished with care and deliberate consideration, certainly. It is a characteristic of the neurotic way that nothing can be done, no new step taken or old one retraced, without painful weighing and measuring, with an agony of indecision precluding any action at all.

We wash the dishes before we vacuum; put on the left shoe first; carry keys in the left pocket and change in the right; read the sports section of the newspaper before the editorials. We perform such things as we do because it's easier, because it's more efficient, or, primarily, because it has become automatic and requires no thought or decision. But we are not distressed or rendered incapable of carrying out the day's activities if a caller drops in before the dishes are done or if someone else grabs the sports pages first. We have probably discovered for ourselves that "a place for everything and everything in its place" really does work best, but a temporary disarrangement will not immobilize us. And, being human, we may be annoyed at the rigidity of the compulsively neat and orderly.

Exaggeration of many normal mechanisms for handling day-to-day living are part of the *obsessive compulsive* neurotic pattern. According to Webster, an obsession is "a persistent disturbing preoccupation with an often irresistible idea or feeling." A compulsion is an "irresistible impulse to perform an irrational act." The word "ruminate," meaning "chew again" when referring in its customary usage to bovines, is the apt term employed by therapists for obsessive compulsive patients. The effects of the condition may be described by such terms as rigidity, indecision, self-disparagement, sensitivity to criticism, rationalizing, and perfectionism.

The common core of agreement among all the many theories about this neurotic pattern is that, like the other neuroses, it is a technique for dealing with life and an attempt to achieve a sense of certainty in a uncertain world, to control oneself and one's surroundings, and to achieve physical and psychological protection from forces and events considered to be threatening. Recently some therapists have attributed it to repressed rage, the struggle to master feelings of insecurity and helplessness, or to confused notions of time and place, even of life and death. These theories serve to explain the indecisiveness which is a hallmark of the syndrome. They clarify, too, the obsessive compulsive's unreasonable concern with an unbelievably wide range of possibilities which he imagines may result because of his actions or thoughts.

Freud believed that the obsessive compulsive unconsciously fended off anxiety with three defense mechanisms: *isolation*, which separates an unacceptable idea or desire from its source in the memory, leading in turn to dissociation of the emotion from that memory; *undoing*, which must follow when isolation will not do the job and attempts to cancel out the forbidden impulses by such activities as checking and rechecking or washing again and again; and *reaction formation*, the adoption of attitudes and behavior which are often repetitious and are directly opposed to one's true impulses.

Many obsessive persons are able to control their lives and environments successfully to all outward appearances but with great

cost to themselves and frequently to those around them, since ordinary human interactions are difficult for them. They can rarely know the relief that comes from making a decision, since each tiny facet must be examined and re-examined, polished and repolished. Their striving for perfection can never be satisfied, nor can they bear to be wrong. Unfortunately, the very qualities of perseverance and devotion to an ideal, which normally are considered admirable and worthy of emulation, are not indicative of psychic health when they manage to blot out all other considerations. However, obsessions with a great idea or goal have given society some of its greatest contributions in new lands discovered, new serums synthesized, or old knowledge preserved.

Obsessive thoughts may be compared to the familiar occurrence of a tune which continues to echo unbidden in one's head, sometimes re-echoing for hours. The obsessive must contend in this way with worries about past actions, decisions about future problems, or, worse, visions of some catastrophe to himself or someone close to him. Like everyone, such a person will be bothered by needless and distressing recollection of an unpleasant experience, an error in judgment, or thoughtless, hurtful comments. It is the unrelenting persistence of such ruminations which sets the obsessive individual apart. The abhorrence inherent in constant reflections about such things as stabbing one's spouse, or private bodily functions, or fear of committing an obscene act in public is easy to imagine. It is no wonder that, as the disturbing thoughts chase round and round, the individual thus obsessed may take extreme measures to exorcise them.

To counteract or to avoid acting on or even thinking about such impulses, the obsessive person follows a natural tendency to substitute with other thoughts and actions. Thus he may become good to the point of stiff prudishness or preoccupied with the accomplishment of a number of set tasks to the extent of creating an extreme imbalance with other aspects of living. The relief of these ruminations by ritualized behavior forms the compulsive actions which render the harassed individual's life even more obviously neurotic to the rest of the world.

Ritualized compulsions—checking again and again, washing and rewashing, knocking on a door a prescribed number of times—ease aggressive or hostile drives and overcome uncertainty and doubt, at least temporarily. The performance of most of these neurotic compulsions doubtless seems as bizarre and senseless to the person who is compelled to perform them as it does to the observer.

True kleptomania, dangerous and guilt producing though it be, is considered a compulsion. Washing the hands until the skin is raw, checking the position of a certain chair 10 times, or blinking the left eye 11 times in succession are not unusual examples of the compulsive neurosis at work. One quite ordinary-looking man on

a London street was observed to pause several moments in a doorway in which he could see his reflection and then to pace off eight or nine long steps, rapidly and stiffly. He returned to his starting place and repeated the action, stopped, took another set of measured paces, then continued walking unhurriedly and unobtrusively away with other pedestrians, his discomfort apparently eased for awhile, at least.

The impulses for which such seemingly unnecessary, foolish actions could substitute are hard to imagine. What emotions are these compulsively driven people "undoing"? Parenthetically, it could be observed that many people within the normal range of behavior might question the strength of the obsessive compulsive dynamism in obesity, alcoholism, or even "workaholism."

Fortunately, this neurosis may sometimes dissipate along with the stress which precipitated it. Therapy is usually difficult. For one thing, diagnosis and subsequent treatment are understandably hard in the case of an individual with overlapping symptoms. A crippling obsession compounded with the compulsive avoidance factors in a phobia or a compulsive repetitive act combined with hysteria can be formidable indeed, both in family dynamics and in therapeutic restoration.

Another element in the difficulty is that the would-be patient is the principal sufferer. Even families badly affected by the neurosis of one member may be hesitant about doing anything, and one person's compulsions are infrequently a problem to society as a whole. Neither of these groups, then, would necessarily influence an individual to seek therapy and, especially, to see it through. Actually, the syndrome interferes very little in the daily comportment of some people and may even be quite comfortable. Certainly, even the interruptions of a nagging obsession or the embarrassment of a noticeable compulsion may be more comfortable than the frightening interim between the disposal of old patterns of behavior and the assumption of new ones—yet another factor to be overcome in therapy.

Any therapeutic intervention of this neurosis should have as its principal aim the teaching of new and better ways to handle social situations. In psychoanalytic therapy, this will be attempted by first identifying, then clarifying for and with the patient, the patterns of defense he has been using. Finally will come alteration of these patterns when his ego has been strengthened, a process which may be lengthy. It is hoped that, during treatment, the patient will be guided to substitute new, constructive actions and reactions for the old, destructive ways.

Some obsessive compulsive persons have been treated by a light hypnosis, accompanied by acting out the annoying obsessions at the therapist's directions, and followed by a light electroconvulsive shock. Other therapists have used a combination of antidepressant drugs, to relieve the depression which frequently accompanies this

neurosis, and an axiolytic agent, for the reduction of anxiety which may arise while the patient's defenses are down. These must be combined with good judgment and great skill, both clinical and psychotherapeutic. Research on this form of therapy is continuing, as it is on other treatments.

Many therapists, who consider that both phobic and obsessive compulsive neuroses are responses which have been learned in order to cope with stressful situations, hold that "unlearning" through some form of behavior therapy is the most effective treatment. The therapist must, of course, have empathy for the distress and desire of his patient and, in the course of therapy, he may aid his client in gaining insight into the background of the condition and into the means of continuing and fostering improvement after the formal sessions have ended. Customarily, the therapist will explain the course the treatment is expected to follow. The patient will be advised as to what he may expect from the therapy and, in turn, what the therapist expects, and usually he will be told that he is not alone in experiencing the unbidden thoughts and impulses from which he is seeking relief. Some patients begin with a light dosage of an antidepressant drug for the relief of the tension and anxiety which frequently accompany this syndrome.

In many cases, the patient reinforces his involvement by keeping his own records, after furnishing the therapist data on the intensity and duration of his rumination or his rituals. He may then be assigned the job of making a note of the extent of discomfort experienced each time he does not allow himself to put right or neutralize the recurrence of a guilty thought or worrisome impulse. For instance, the housewife, so concerned about filth that she washes the same laundry three times over, when required to let one cycle of the washing machine suffice, will at first become almost physically ill from uneasiness. Over a period of time, she will be gratified to observe the factual proof that the duration of her discomfort has decreased considerably or disappeared altogether. (The entire family may show improvement.) Or, the businessman, who, convinced that he sometimes destroys valuable company papers, checks his desk drawers and filing cabinets thoroughly four times a day, will have great difficulty in preventing this checking and rechecking at first. Eventually, not only his record but his own sense of well-being will reward his therapeutic ordeal.

Punishment is used effectively in many ways, by therapist and patient together and by patient alone. One patient may be forbidden to make a certain gesture, such as stroking his chin three times from left to right; another may be instructed not to ruminate, but to change his thought pattern forcibly and suddenly each time the troublesome idea surfaces to his consciousness. Would-be dieters and not-quite nonsmokers can sympathize with the patient on this assignment, another proof that a therapist can do relatively little without the will and cooperation of the patient.

Small rewards given at certain intervals can be effective, too. A student who cannot concentrate when preparing for a crucial professional examination because of ridiculous intrusive thoughts may be told that he will be allowed 5 minutes for his other thoughts after 20 minutes of uninterrupted study. Thus, the useless dreams become useful stimuli, rewards for steady concentration. Therapist and patient, between them, can work out a system of small rewards for thought stopping or behavior stopping.

Satiation therapy also shows great promise. To rid himself of a bothersome tic, such as a blinking eye or a facial twitch, the patient is required to perform the annoying act over and over to the point of fatigue. After a number of sessions, it becomes obvious to the patient that the action can be caused at will. Before too long, the muscles cease to jerk and the tic fades. Happily, the offensive habit is normally not replaced by another symptom. It is probable that the patient is so encouraged by success and by the realization of his own mastery that he is emotionally ready for further successes. A less visible but similarly productive use of this technique is its application with ruminations, in which the individual forces himself to summon a worrisome thought to his consciousness deliberately and to retain it, a process which grows increasingly difficult until, eventually, the thought rarely returns unbidden.

Phobia

Phobias, and the impressive Greek names by which they have been called, are perhaps the best known of the neuroses. Certainly they are the most morbidly fascinating. And in a list of phobias nearly every letter in the alphabet is represented at least once. A sampling from the A's *alone* includes *acrophobia*, fear of heights; *algophobia*, obsessive fear of pain; *amaxophobia*, dread of riding in a vehicle; *androphobia*, unnatural fear of men; and *anthophobia*, unreasoning dread of flowers. It is possible to proceed through the alphabet, listing feelings of dread which all people might recognize—*claustrophobia*, fear of enclosed spaces, is a familiar one—as well as many fears which seem farfetched.

Somewhere in the middle of a complete list loom reactions which many have known personally, the dread of being alone, or *monophobia*, and *mysophobia*, fear of dirt, a condition which many a small boy may think his own mother invented. In the T's appears an obsessive fear surely having its roots in superstitious awe of the number 13, *triskaidekaphobia*. The alphabetic search ends with *xylophobia*, fear of trees and other wooded plants, and *zoophobia*, a morbid fear of animals.

Just as the colors chosen for new clothing or interior decoration change with the whim of fashion, so, to some extent, do the neuroses. For instance, the grandiose terms borrowed from the Greek language to describe the phobias are no longer considered com-

pletely useful by some therapists; they are cumbersome, and they suggest a number of different disorders rather than symptoms of deeper problems which, in reality, may be unrelated to the ostensible fear, the one that shows. Some therapists include most of these under the heading of Panic Disorders. Furthermore, changes in styles of phobias have occurred through changes in social structure or living conditions. In today's crowded world, for example, *agoraphobia*, usually defined as a fear of open spaces, refers to one who feels too insecure away from home to participate in the busy life of the bustling street or shopping center. Thus the prefix "agora" is apt indeed—to the ancient Athenian it was the market place.

Recent technological discoveries engender new phobias, too, or give new impetus to old ones. Fear of flying is relatively recent in origin, and exploration of outer space has revived *barophobia*, the fear of living on a planet which is hurtling through the atmosphere at unbelievable speeds. Closely allied is *astrophobia*, the morbid fear of celestial phenomena, historically evidenced in man's dread at the approach of infrequently viewed comets.

Phobia, whose nature was first recognized by Hippocrates, may be rendered more comprehensible by the less customary meaning of the Greek word "phobus." It meant flight, running away, escape. Phobia, then indicates an overall pattern of fear and avoidance. A *keraunophobic*, one who is terrified at storms, thunder, and lightning, avoids the noise and flashing light by lingering in a dark hallway or other windowless area until the storm abates; a *claustrophobic* walks up many flights of stairs rather than enter a small crowded elevator, while his opposite, a *climaphobic*, will go to any lengths to avoid the dreaded stairs.

The fear sensation is common to everyone. Healthy caution is a part of survival, and respect for danger is a prudent part of living. They are instinctive. Instincts become phobias when they are exaggerated to the point of dominating one's life, or when the thing feared is feared out of all proportion to reality. The term phobia is appropriately used also when there is no perceptible danger attached to the stimulus, as in unnatural horror aroused by certain colors, an unusual example known as *chromophobia*. Phobia is an apt diagnosis, as well, when the type and extent of the fear are completely out of character with the rest of the individual's habits and personality. (Napoleon's *ailurophobia*, fright at the sight of a cat, is certainly difficult to reconcile with the emperor-general image.)

Ten million Americans are said to suffer from phobias, to greater or lesser degree, with more young women than men in the group, as in the neurotic syndrome as a whole. (It has been unmanly to show fear in our society.) And as with the other neuroses, there are few statistical inferences from which to draw, other than observations by researchers and therapists, such as the

conclusion that individuals who are introverted and have a high measure of neuroticism are more likely to fall prey to a phobia or an anxiety state than to other types of neurosis. Proportionally, the more exotic phobias occur infrequently, while acrophobia, agoraphobia, claustrophobia, plus the interpersonal phobias, sexual phobias and death-disease-injury phobias are the most widespread.

Phobia has been called the "neurosis of childhood," since some phobias resemble childhood fears and because acting afraid frequently engenders a sympathetic response and a release from the fulfillment of responsibilities. Impressions from a childhood trauma, such as a nasty bite, a destructive storm, or a gory accident, may linger long after the parent or pediatrician believes the hurt to be healed and forgotten. A desire to avoid repetition of such an experience is understandable. Childhood can be the time of learning to profit from the experience of hurts and to deal with most fears. Alternatively, it can be the time of learning fears which may terrorize, even incapacitate, adulthood. Anxious parents can produce anxious children. Overprotective parents can inhibit a child's ability to cope with the normal apprehensions which accompany new experiences. The process of living may become a burden rather than an adventure.

Fortunately, many people learn to live with their phobias, with little inconvenience to themselves or others. Making sure to engage the aisle seat in a theater, for example, or the inside seat in a plane, may render a mild phobia manageable. And sheer necessity has been known to aid some individuals in apparently ridding themselves of the disorder altogether. Consider the case of the young father whose coveted pay raise depended on his checking stock in a small, enclosed room crowded with packing cases. He found his sweaty palms and shortness of breath less debilitating each time he visited the stock room and was gradually able to lengthen his stays there. In therapeutic parlance, *frequent or repeated contact with a fear-producing stimulus tends to weaken*, possibly *even remove*, its capacity to arouse symptoms of panic. The corollary of this is clear: *A fear-producing stimulus is usually strengthened by successful avoidance*. Begging off by getting someone else to check stock might have cost the young man his new job. Worse, he would have found his claustrophobia unmanageable if he had not, little by little, defeated it in the beginning.

Many who suffer from the symptoms accompanying a panic attack are not as fortunate. The sensations of suffocation or faintness, trembling, rapid breathing or breathlessness, nausea, or muscular weakness are too severe. At the present, more and more of these people are wisely seeking therapeutic help. The therapeutic techniques employed vary according to the orientation of the therapist, who may use psychoanalysis, desensitization, reassurance, or a combination of approaches. The therapy may be in either an

individual or a group setting, and with or without the use of drugs.

Sally has been a victim of agoraphobia for a number of years. Raised in a small town, she was a popular member of a well-known family. After marriage, she moved to a city where she knew few people. She was expected, as a "company wife," to entertain frequently and to take part in many civic and social affairs. As time went by she experienced greater dread each time she was required to leave her home and mingle with others, actually becoming panicky in crowds. Gradually the fear generalized, and she found it difficult to attend parties with her husband or to drop in at neighborhood coffees. She stopped going to church, was unable to do her grocery shopping or, one of her former delights, clothes shopping, and could not participate in parent-child activities outside of her own home.

A therapist using the psychoanalytic approach would attempt to discover the possible causes of Sally's phobia—a scary search for a parent through the aisles of a store crowded with adults who towered over her? Over-protective parents? Security based only on family status in her hometown, with no conviction of her own worth? An inner conflict which was not resolved in childhood? Displacement of the anxiety occasioned by meeting her husband's worldly friends into a panic about going out at all?

Through talking with a psychoanalyst, Sally is led to understand the origins and meaning of her phobia. Hopefully, she will learn to cope with both the situations she fears and with the anxiety which has caused her problem.

There are many therapists who do not believe that understanding is sufficient or effective. Facing and conquering a fear which has dominated one's thoughts and habits may be impossible for some, even though their minds tell them that the fear is groundless. Further, the procedure seems prolonged in an age when people expect fast relief.

Therapists who use the behavioral strategy have substantiated the strengthening-by-avoidance/weakening-by-contact principle of coping with a fear-producing stimulus. In cases of specific animal phobias, for example, patients have been taught to accept the proximity of a feared and loathed creature by gradually having closer contact or by being led to imagine and discuss their dread until, a bit at a time, their anxiety diminishes to a bearable level or, in many cases, disappears entirely.

If Sally decides on this *behavior therapy* as her treatment of choice, she will first be trained to relax. Relaxation will be achieved through yoga-like exercises of breathing deeply and imagining pleasant experiences, by minimal dosages of drugs, or by hypnosis or meditation. During this same period, she will be led to the construction of hierarchies, that is, to listing her anxieties in the order of their power over her. Does she dread a cocktail party where she must make small talk with strangers more than she fears going to the supermarket? Is she more afraid of chatting with her husband's boss at dinner than returning a dress that doesn't fit properly?

Once Sally and her therapist have taken the important first step of categorizing her fears appropriately, the process of systematic desensitization can begin. The therapist may show Sally pictures of happenings which illustrate her fears or he may describe the situations to her and ask her to imagine herself attending a party, going to the store, and so on. Sally, in turn, must indicate to the therapist the point at which a particular episode is too painful to continue at that time. Later, when that episode no longer induces feelings of terror, the next fear in the hierarchy is dealt with in the same fashion, and the next and the next, until Sally can remain relaxed while imagining herself involved in many events and, eventually, can resume a more active role outside the shelter of her own home.

Recently there have been a number of accounts of phobia clinics and even of a series of classes conducted by an airline to cure fear of flying. News stories about the Phobia Clinic at New York's Long Island Jewish-Hillside Medical Center in New Hyde Park have aroused great interest and hope among sufferers of the phobic disorders. The program, which makes extensive use of behavior therapy techniques, has been funded by a research grant from the National Institute of Mental Health. The reported success rate, about 80 percent, is exciting, and the testimonies of those who have been helped are glowing. Their histories include bouts with acrophobia, claustrophobia, fear of speaking in public or even of responding in the classroom. In cases where a patient indicates trouble from more than one pervading fear, the phobias are taken one at a time. Therapy at the clinic consists of both individual and group sessions and proceeds according to formula: relaxation, construction of hierarchies, and systematic desensitization.

One dramatic account is of a young woman badly afflicted with acrophobia and claustrophobia. During the first of her 26 sessions, the usual length of treatment at the clinic, she was invited to relax comfortably, with feet up and eyes closed, take three deep breaths, and imagine herself floating lightly to a peaceful, relaxing spot. Once her mind was at ease, she concentrated on gradually relaxing her muscles, from her scalp to her toes. The therapist used the rest of the 45-minute session in guiding her to imagine herself on the third floor of a tall building, looking out a window. In her imagination she ascended, a few floors at a time. Whenever she became anxious, she raised a finger. At this signal, the therapist advised her to forget it for awhile, relax and begin again. As treatment went on, she completed the hierarchy in imagination and went higher and higher in a real building, still only a few floors at a time. Her ultimate victory was going to the top of the Empire State Building and out onto the observation deck where she was able to go to the edge and look down. Later, her claustrophobia was conquered as well.

Dr. Charlotte Zitrin, director of the clinic, calls *agoraphobia* the

most serious and most difficult to treat of the phobias because of its all-pervasive dominance over its victim's life. By her estimate, six of every 1,000 people are agoraphobic. Of these, four out of five are women—England's name for the disorder, "homebound housewife's syndrome," is apt indeed. Dr. Zitrin suggests that women from certain of the ethnic groups served by her hospital are more prone to agoraphobia because of their close-knit, protective upbringing. Further, she has observed that there are some husbands who may subtly encourage the condition in their wives, preferring them to remain dependent homebodies.

Agoraphobics have been found to be especially responsive to minimal doses of imipramine, an antidepressant effective in curbing panic attacks. For a month before other therapy begins, some of the patients take imipramine every evening. In accordance with standard research procedures, others are given a placebo, or "pretend" medication, in order to measure the effectiveness of the drug portion of the therapy. The reported success-rate with the patients receiving imipramine and therapy is 91 percent, and with the patients receiving placebo and therapy, 71 percent.

During group therapy sessions, small groups of patients go with a staff member on field trips to a neighborhood shopping center, a restaurant, or to a department store in New York City. After traveling together a few times, they separate, walk through the area alone, and make the trip back alone.

Remembering that first trip alone still brings dismay, but, according to some of the women, it was a turning point. One woman recalls weeping bitterly when she was forced to cross a wide street by herself on that first venture. She recalls, also, her sense of triumph. Some of the patients admit to their phobia being arrested rather than cured, but state that, with a bit of extra effort, they can go anywhere now, on their own.

Some behavioral therapists favor another technique, *implosive therapy*, because usually it achieves results more quickly than does systematic desensitization. Others disagree, saying that while many phobic persons are helped, many others appear to suffer more intensely after therapy. Implosive therapy seems the antithesis of desensitization, since it requires that the patient be bombarded with descriptions of situations and events which stimulate the terrors revealed early in therapy. The patient is forced to imagine or live through these experiences vividly, in some cases with the use of hypnosis or drug therapy to render the imagination more suggestible. As the therapist perceives that anxiety related to any one episode is exacerbated, he "loads" the patient with more. In cases where the patient's imagination is weak or unrealistic, the therapist may even recommend a real-life experience to prove to the patient that the fears dominating his life have little basis. Apparently, the fear stimulus evokes less anxiety in a secure setting, and, therefore, habits of avoidance are eradicated.

There are many ways, then, to cure a phobia. Remembering that frequent or repeated contact with the fear-producing stimulus, or imagining it vividly enough, tends to weaken the power of that stimulus, some individuals can, alone or with the help of a family member or friend, desensitize themselves. As Dr. Zitrin pointed out, "just edging closer is desensitization."

Help from a professional therapist is advisable for most people with neurotic symptoms, of course, and required for many. It has been observed that about two-thirds of nonpsychotic patients benefit from one or the other forms of psychotherapy, showing improvement in personality and mood as well as in thought and behavior patterns. Some persons have appeared to heal themselves, either through conscious will, a change in lifestyle, or removal of the stress which helped to produce the neurotic symptoms.

It is clear that all of the psychotherapies are growing, expanding, and changing, and that new ones will continue to evolve as the times and people's needs change; there is the possibility that more psychotherapists will come to employ a combination of therapies, according to their patients' particular reactions. Certainly finding the therapy and the therapist most compatible with one's needs and philosophy is most important.

Help can be found at most community walk-in or store-front clinics and community mental health centers, in the outpatient clinics of either the department of psychology or the department of psychiatry of major medical centers, or from psychiatrists or psychologists in private practice. Physicians in general medical practice are frequently able to furnish such referrals as are most pastors and rabbis, many of whom are themselves trained and skilled in counseling and informed about such resources. For many people, self-help groups, such as Neurotics Anonymous, are the answer.

It probably won't be easy. Coping with life isn't always easy. But being able to cope—living, working, playing as most people do—should be worth the trouble.

References

The following references were useful in the preparation of this work. Entries preceded by an asterisk are suggested as additional reading for persons interested in studying about neurotic disorder in greater depth.

Celani, David. An interpersonal approach to hysteria. *American Journal of Psychiatry*, 133(12):1414-1418, 1976.

Chesser, Edward S. Behaviour therapy: Recent trends and current practice. *British Journal of Psychiatry*, 129:289-307, 1976.

*Coleman, James C. *Abnormal Psychology and Modern Life*. Fourth edition. Glenview, Ill.: Scott, Foresman and Co., 1972.

Cox, David. *Modern Psychology: The Teachings of Carl Gustav Jung*. New York: Barnes & Noble, 1968.

Crosby, John F. Theories of anxiety: A theoretical perspective. *American Journal of Psychoanalysis*, 36(3):237-248, 1976.

Dyrud, Jarl. Toward a science of the passions. *Saturday Review*, 22-27, February 21, 1976.

Eysenck, Hans J. *The Dynamics of Anxiety and Hysteria An Experimental Application of Modern Learning Theory to Psychiatry*. New York: Frederick A. Praeger, 1957.

Feldman, Larry B. Depression and marital interaction. *Family Process*, 15(4): 389-395, 1976.

Galton, Lawrence. How to overcome a phobia. *Parade*, August 8, 1976.

Gorlow, Leon, and Katkovsky, Walter, eds. *Readings in the Psychology of Adjustment*. Second edition. New York: McGraw-Hill, 1968.

Johnson, Richard E. *Existential Man: The Challenge of Psychotherapy*. Elmsford, N.Y.: Pergamon Press, 1971.

Jung, C. G. *Modern Man in Search of a Soul*. (1911) Translated by W. S. Dell and Cary F. Baynes. New York: Harcourt, Brace and World.

Kanfer, Frederick H., and Karoly, Paul. Self-control: A behavioristic excursion into the lion's den. *Behavior Therapy*, 3(3): 398-416, 1972.

Klemesrud, Judy. Conquering a phobia that makes a healthy woman stay home. *The New York Times*, August 6, 1976.

Kline, Nathan S. *From Sad to Glad*. New York: G. P. Putnam's Sons, 1974.

Kotulak, Ronald. Too much of a bad thing may cure that neurosis. *Chicago Tribune*, June 27, 1976.

Kotulak, Ronald. Your defenses: Ego trip up or down. *Chicago Tribune*, August 1, 1976.

Lindzey, Gardner, and Hall, Calvin S., eds. *Theories of Personality: Primary Sources and Research*. New York: John Wiley & Sons, 1965.

Loew, C. A.; Grayson, H.; and Loew, G. H. *Three Psychotherapies: A Clinical Comparison*. New York: Brunner/Mazel, 1975.

London, Perry. The end of ideology in behavior modification. *American Psychologist*, 27(10): 913-920, 1972.

*Martin, Barclay. *Anxiety and Neurotic Disorders*. New York: John Wiley & Sons, 1971. (Approaches to Behavior Pathology Series)

Maslow, A. H. *The Farther Reaches of Human Nature*. New York: Viking Press, 1971.

McLellan, Diana. Eek! It's the dreaded phobia. *The Washington Star*, February 8, 1976.

*McMahon, Frank B. *Abnormal Behavior: Psychology's View*. Englewood Cliffs, N.J.: Prentice-Hall, 1976.

*McNeil, Elton B. *Neuroses and Personality Disorders*. Englewood Cliffs, N.J.: Prentice-Hall, 1970.

Mozdzierz, Gerald J.; Macchitelli, Frank J.; and Lisiecki, Joseph. The paradox in psychotherapy: An Adlerian perspective. *Journal of Individual Psychology*, 32(2): 169–185, 1976.

Parloff, Morris. *Shopping for the Right Therapy*. DHEW Pub. No. (ADM) 77-426. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1977. Reprinted from *Saturday Review*, 14–20, February 21, 1976.

Piaget, Jean, and Inhelder, Barbel. *The Psychology of the Child*. Translated by Helen Weaver. New York: Basic Books, 1969.

*Rachman, S. *Phobias, Their Nature and Control*. Springfield, Ill.: Charles C Thomas, 1968.

Rachman, S. The modification of obsessions: A new formulation: *Behaviour Research and Therapy*, 14(6): 437–445, 1976.

Rachman, S., and Roper, G. The spontaneous decay of compulsive urges. *Behaviour Research and Therapy*, 14(6): 445–455, 1976.

Rosen, Ephraim, and Gregory, Ian. *Abnormal Psychology*. Philadelphia: W. B. Saunders, 1965.

*Rosen, Ephraim, and Gregory, Ian. *Abnormal Psychology*. Philadelphia: W. B. Saunders, 1965.

Rosenfeld, Albert. And now, preventive psychiatry. *Saturday Review*, 24–25, February 21, 1976.

Rothgeb, Carrie Lee, ed. *Abstracts of the Standard Edition of the Complete Psychological Works of Sigmund Freud*. DHEW Pub. No. (HSM) 72-9001. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1972.

Ryle, Anthony. *Neurosis in the Ordinary Family*. London: Tavistock, 1967.

*Salzman, Leon. *The Obsessive Personality: Origins, Dynamics, and Therapy*. New York: Science House, 1968.

Segal, Julius, and Segal, Zelda. Handling your anxieties. *Seventeen*, 146–147, 184, March 1977.

Skinner, B. F. *About Behaviorism*. New York: Alfred A. Knopf, 1974.

*Snyder, Solomon. *The Troubled Mind: A Guide to Release from Distress*. New York: McGraw-Hill, 1976.

*Suinn, Richard M. *Fundamentals of Behavior Pathology*. Second edition. New York: John Wiley, 1975.

Thorne, Frederick C. A new approach to psychopathology. *Journal of Clinical Psychology*, 32(4): 751–756, 1976.

Ullman, Leonard P., and Krasner, Leonard. *A Psychological Approach to Abnormal Behavior*. Second edition. Englewood Cliffs: Prentice-Hall, 1975.

Vaillant, George E. Natural history of male psychological health. V. The relationship of choice of ego mechanisms of defense to adult adjustment. *Archives of General Psychiatry*, 33:535–545, 1976.

Wolpe, Joseph. *The Practice of Behavior Therapy*. New York: Pergamon Press, 1969.

*Woodruff, R. A.; Goodwin, D. W.; and Guze, S. B. *Psychiatric Diagnosis*. New York: Oxford University Press, 1974.

50 U.S. GOVERNMENT PRINTING OFFICE : 1978 O—270-937